Manual for the Comprehensive Health Assessment Tool (CHAT): Young People in the Secure Estate

June 2013 (version 3)

Title: *CHAT Manual: Young People in the Secure Estate*

First published: *June 2013*

Published to OHRN website, in electronic PDF format only
http://www.ohrn.nhs.uk

The **Offender Health Research Network** is funded by Offender Health at the Department of Health, and is a collaboration between several universities, based at the University of Manchester. It was established in 2004 to develop a multi-disciplinary, multi-agency network focused on offender health care innovation, evaluation and knowledge dissemination.

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Acknowledgements

The tool has been developed in partnership with the Department of Health and Youth Justice Board with special thanks to: Caroline Twitchett and Howard Jasper.

In the development of the CHAT and manual we would like to thank the following professionals for their contribution: Rakib Abdur, Catherine Aldred, Liz Allan, Ruth Andrews, Georgina Bebbington, Guy Blackstone, Kirsten Blohm, Steven Boyd, Karen Bryan, Sam Cox, Ilana Crome, George Dodds, Emily Farrow, Deborah Fortescue, Juliette Gregory, Jonathan Green, Thomas Grisso, Ray Hill, Linda James, Maggie Johnson, Mike Lowry, Jo Marshall, David Marteau, Karen McKenzie, Paul Mitchell, Robert Newman, Mary Piper, Seb Potter, Rosalyn Proops, Andrew Plumtree, Helen Rodwell, Mary Ryan, Clare Snodgrass, Sue Sylvester, Jo Tunnard, Anthony Thompson, Louise Wilkinson, Huw Williams, Susan Young.

We acknowledge the key role undertaken by staff at: HMP & YOI Hindley, HMP & YOI Wetherby, HMP & YOI Ashfield, HMP & YOI New Hall, Vinney Green Secure Unit, Barton Moss Secure Care Centre and Hassockfield Secure Training Centre.

Glossary of Terms

ABI	Acquired Brain Injury
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
ASC	Autistic Spectrum Condition
BMI	Body Mass Index
BPS	British Psychological Society
CAMHS	Child and Adolescent Mental Health Services
CAIDS	Child and Adolescent Intellectual Disability Screening Questionnaire
CBT	Cognitive Behavioural Therapy
CHAT	Comprehensive Health Assessment Tool
CIAW-B	Clinical Institute Assessment of Withdrawal – Benzodiazepines
CIWA-Ar	Clinical Institute Withdrawal Assessment – Alcohol
COWS	Clinical Opiate Withdrawal Scale
DH	Department of Health
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders Version 4
GAD	Generalised Anxiety
HMP	Her Majesty's Prison
IAPT	Improving Access to Psychological Therapies
IHA	Initial Health Assessment
IQ	Intelligence Quotient
ICD-10	International Classification of Diseases Version 10
LAC	Looked after Children
LoC	Loss of Consciousness
MAPPA	Multi-Agency Public Protection Arrangements
NICE	National Institute for Health and Clinical Excellence
PDD	Pervasive Developmental Disorder
PTSD	Post Traumatic Stress Disorder
PLI	Pragmatic Language Impairment
RGN	Registered General Nurse

RLDN	Registered Learning Disabilities Nurse
RMN	Registered Mental Nurse
RNC	Registered Nurse (specialising in children)
SCH	Secure Children's Home
STC	Secure Training Centre
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBI	Traumatic Brain Injury
YJB	Youth Justice Board
YJS	Youth Justice System
YOI	Young Offender Institution
YOT	Youth Offending Team

1 Introduction

This manual has been designed for use alongside the Comprehensive Health Assessment Tool (CHAT) for Young People in the Secure Estate. It is important that practitioners receive training in how to use the tool prior to using the CHAT. This manual aims to provide guidance, supplementary signposting and contains additional information relevant to all sections of the CHAT.

Health inequalities tend to be high amongst children and young people in contact with the youth justice system (YJS). It is acknowledged that a central goal in the YJS is to enable young people to address their offending behaviours. However, research has demonstrated that children and young people who offend are less likely than their peers to have their health needs recognised and these needs tend to remain unrecognised and unsupported when they enter the YJS (Kroll et al., 2002; Chitsabesan et al., 2006). Assessing and managing unmet health needs can inform individual care plans addressing offending behaviour and enhance discussions about a young person's future, for example training and education opportunities. Some young people lead chaotic lives, and may have no fixed abode and no source of primary care. Time within the secure estate may provide a valuable opportunity to re-engage with treatment such as ongoing monitoring of asthma or to attend to unmet health needs e.g. undiagnosed Autistic Spectrum Disorders (ASD). Early identification and support is key to changing the lives of young people.

The CHAT provides a consistent way of recording information about a young person. The implementation of secure and community versions of the CHAT could ensure that valuable health information travels with a young person enhancing rehabilitation and compliance as well as health and wellbeing.

Why has this tool been developed?

There is growing evidence that young people in the youth justice system have higher levels of health needs than their peers and that as younger children, they had lower levels of access to healthcare provision. Furthermore, the experience of being in the secure estate can exacerbate health problems, the assessment and treatment of which can complicated by transfers from one unit to another.

While it is acknowledged that much good local practice exists, this practice does not always address all health domains consistently. The CHAT seeks to provide a comprehensive assessment of need in all of the health domains and guidance on developing pathways to local specialist care.

2 Background

Children and young people who are in contact with the YJS are frequently a socially excluded population with significant and complex health needs. These health needs are often unmet in a number of key areas, including physical health, mental health, and substance misuse. These needs are often exacerbated by poverty and limited family support (University of Liverpool, 2012) resulting in young people receiving little support to access healthcare throughout their lives.

'Healthy Children, Safer Communities' is a strategy to promote the health and well-being of children and young people in contact with the YJS (HM Government 2009). This document has generated many workstreams and is one of the drivers for the development of the CHAT. These drivers include improving provision of primary and specialist healthcare services to children and young people who offend; ensuring that courts and bodies who deliver sentences receive accurate information about health and well-being needs and the services to meet them; promoting health and well-being in the secure estate; and achieving continuity of care when children complete a sentence.

'Healthy Lives, Healthy People' emphasises the need to improve the health of the most "disadvantaged, vulnerable and excluded groups" (Department of Health [DH], 2012). It is hoped that the implementation of the CHAT will contribute to an increased identification of health needs in this population and result in more comprehensive multi-agency commissioning.

2.1 Physical Health Needs

Increasing awareness of the physical health needs of young people in contact with the YJS is evidenced by the joint initiative between the Royal Colleges of Paediatrics and Child Health, Nursing, Psychiatry, General Practitioners and the Faculty of Public Health. This initiative aims to develop standards for the healthcare of young offenders. The Office for National Statistics (Lader et al., 2000) collected data on 16 – 20 year old prisoners in England and Wales. Five hundred and ninety of the 632 young people selected, agreed to take part, possibly suggesting that young people are keen to share their experiences and needs. The survey found that a quarter of male and a third of female young people who offend reported longstanding physical complaints. Respiratory problems were the most common finding in both males and females, followed by musculo-skeletal problems in males, and nervous system complaints e.g. migraines in females.

The Youth Justice Board (YJB, 2006) examined the mental and physical health care needs of 17-year-old females in Young Offender Institutions (YOIs) using a health questionnaire compiled for the study and the General Health Questionnaire. Seventy-nine percent of respondents reported a longstanding illness or disability, including migraine and persistent headaches (31%), back pain (23%) and asthma (19%). Almost a quarter of the young women (23%) had at some time been diagnosed with a sexually transmitted infection (STI). Finally, as noted by Ryan and Tunnard (2012) young people in contact with the YJS have a range of additional risk factors impacting on their physical health. These include use of street drugs, cigarettes and alcohol, unsafe sex, limited diet and obesity and limited contact with general practitioners and dentists.

2.2 Substance Misuse Needs

Garside (2009) interviewed 231 young people in custody aged between 12 and 18 years. The study found that adolescents took large quantities of alcohol and drugs prior to entering the secure estate; 67% of the young people got drunk at least once a week, and 16% were getting

drunk every day. The secure estate may provide a key opportunity for assessment, treatment and advocacy for affected young people. Furthermore, Gudjonsson et al. (2012) found that smoking, alcohol use and substance misuse were all significantly related to Attention Deficit Hyperactivity Disorder symptoms.

2.3 Mental Health Needs

The mental health of all offenders has been brought to public attention with the Bradley report (2009). This report acknowledges the developmental differences between children and young people and adults, and the key role staff playing in the screening for unmet health needs within the secure estate.

The prevalence of mental health problems among young people in contact with the YJS is much higher than the general population. Lader et al. (2000) found that the prevalence rate for psychosis in the past year based on clinical interview data was 10% for male sentenced children and young people who offend. The rates were significantly higher than the 2 per thousand (0.2%) found in the population aged 16–19 resident in private households (Meltzer et al., 1995). Studies have shown high rates of depression (13-22%) and anxiety (21-31%) in young offender populations as well as a high prevalence of suicide attempts (11-16%; Lader et al., 2000). A recent study found that approximately one third of children and young people who offend had a mental health need and 1 in 10 reported self harming within the past month (Chitsabesan et al., 2006).

2.4 Neurodisability

Research studies suggest young people who offend have disproportionately high levels of neurodisability. A recent review by the Office of the Children's Commissioner (Hughes et al., 2012), on the prevalence of neurodevelopmental disorders in young people within the secure estate, has highlighted significant unmet needs due to lack of identification and difficulties accessing appropriate support and intervention.

2.4.1 Learning Disability

Chitsabesan et al. (2007) found that generalised learning disability is significantly more common in young people in custody (23-32%) compared with 2-4% of the general population. The majority have impairment in the mild range (Intelligence Quotient; IQ 50-69) which may be overshadowed by their challenging behaviour. Many young people in contact with the YJS may also have a reading or reading comprehension age below the age of 10 years and therefore may have reduced capacity to follow the legal process and make informed decisions.

Communication disorders include problems with speech, language and hearing that will significantly impact upon an individual's functioning. Research suggests that at least 60% of young people who offend may have impairment in these areas (Bryan et al., 2007). Gregory and Bryan (2011) screened all new entrants to the Intensive Supervision and Surveillance Programme within a youth offending team (YOT) and found that 20% of young people scored as 'severely delayed' and 6% as' very severely delayed'. Many young people in contact with the YJS have deficits in their verbal and performance IQ scores, with particular deficits in verbal skills (Hughes et al., 2012). Some impairment in verbal skills may also accumulate over time through lack of educational opportunities secondary to exclusion and truancy.

2.4.2 Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is characterised by early onset and persistent symptoms of inattention, hyperactivity and impulsivity that are more extreme than is typically observed in individuals at a similar stage of development. While prevalence rates of ADHD in the secure estate have varied across studies depending on the methodology, a rate of 11.7% in males and 18.5% in females was found in one systematic review, compared with 3-5% of the general population (Hughes et al., 2012). ADHD has also been found to increase the risk of offending through the development of conduct disorder, illicit drug use and peer delinquency and is associated with more persistent offending into adulthood (Gudjonsson et al., 2012).

2.4.3 Autistic Spectrum Disorder

There are few prevalence studies of young people with Autistic Spectrum Disorders (ASD) within the YJS, with many studies conducted on a forensic psychiatry sample of young people. However, studies of young people in the YJS suggest an increased prevalence of 2.3- 15% compared with 0.6-1.2% of the general population (Hughes et al., 2012). Certain features of ASD may predispose young people to offend including poor empathy, social naivety and misinterpretation of social cues. Recent studies suggest that about 70% of people with autism also meet diagnostic criteria for at least one other (often unrecognised) psychiatric disorder which may further impair psychosocial functioning (Stanfield et al., 2008). Intellectual disability (IQ below 70) occurs in approximately 50% of young people with autism (Charman et al., 2011).

2.4.4 Traumatic Brain Injury

A traumatic brain injury (TBI) is any injury to the brain caused by impact and is rated from mild to severe depending on the loss of consciousness (LoC) and associated symptoms. Studies suggest that 65-76% of young people in custody reported some form of TBI in comparison with 5-24% of the general population (Williams, 2012). TBI may cause difficulties with language and communication as well as other cognitive problems. Several studies have demonstrated an association with TBI and antisocial behaviour including earlier onset of offending, a greater number of convictions and more violent offending (Williams, 2010).

Consequently, early identification of neurodisability in young people with behavioural difficulties is essential to ensure that secondary impairment due to school failure and social exclusion do not contribute to increased risk of offending through detachment from education and influence of other antisocial peers. However, for those young people with unidentified needs, contact with the YJS can provide opportunities for screening and referral for specialist assessment and support.

3 Development and validation of the CHAT

Since its inception, the YJB has continued to explore ways to improve the health care of children and young people who offend. In response to the high level of unmet health needs within the YJS, the DH and YJB funded a project to develop a new comprehensive health assessment instrument. This project created the CHAT (Bailey et al., 2008). The CHAT contains 5 parts; Reception Health Screen – an initial assessment of immediate risk in physical health, substance misuse, mental health, and immediate safety risks, followed by a comprehensive assessment of Physical Health, Substance Misuse, Mental Health and Neurodisability.

The CHAT has been piloted within HMP&YOI Hindley. Following staff training and implementation of the CHAT, a sample of young people were assessed using standardised assessments in physical health, substance misuse, mental health and neurodisability, by the research team, who were blind to the results from the CHAT (for more details of the research methodology see Lennox et al., 2013).

Overall for the CHAT Physical Health Assessment the sensitivity was 64% and specificity was 59% when compared to the standard physical health examination by a doctor. For the CHAT Substance Misuse Assessment the sensitivity and specificity were as follows; Alcohol 91% 28%; Cannabis 91% 28%; Cocaine 60% 62% and other 53% 75%. Note not all rates could be reported as for some domains the number of true positives, true negatives, false positives and false negatives were zero. For the CHAT Mental Health Assessment the overall sensitivity was 70% and specificity was 79%. Rates for PTSD and Psychosis could not be reported as there were no true positives or false negative, respectively. The sensitivity and specificity for the individual domains were as follows; Anxiety 25% 97%; Suicidal Thoughts 44% 94%; Self-harm 50% 96%, ADHD 14% 83%, and Depressed Mood 67% 93%. For the CHAT Neurodisability Assessment the sensitivity and specificity were as follows; TBI 78% 82%; Speech, Language and Communication Impairment 79% 59%; Learning Disability and Educational Needs 77% 45%. Rates for ASD could not be calculated as there were no true positives or false negatives.

Therefore the CHAT demonstrates good psychometric properties and content validity in screening for health needs. For more details of the research behind the development of the CHAT see Lennox et al., (2013).

4 How to complete the CHAT

4.1 Recommended timescales for completing the CHAT

Figure 1 shows how to complete the CHAT and the CHAT pathway

Reception Health Screen – **before the first night of admission, ideally within 2 hours of admission**

Physical Health Assessment **– within 3 days of admission**

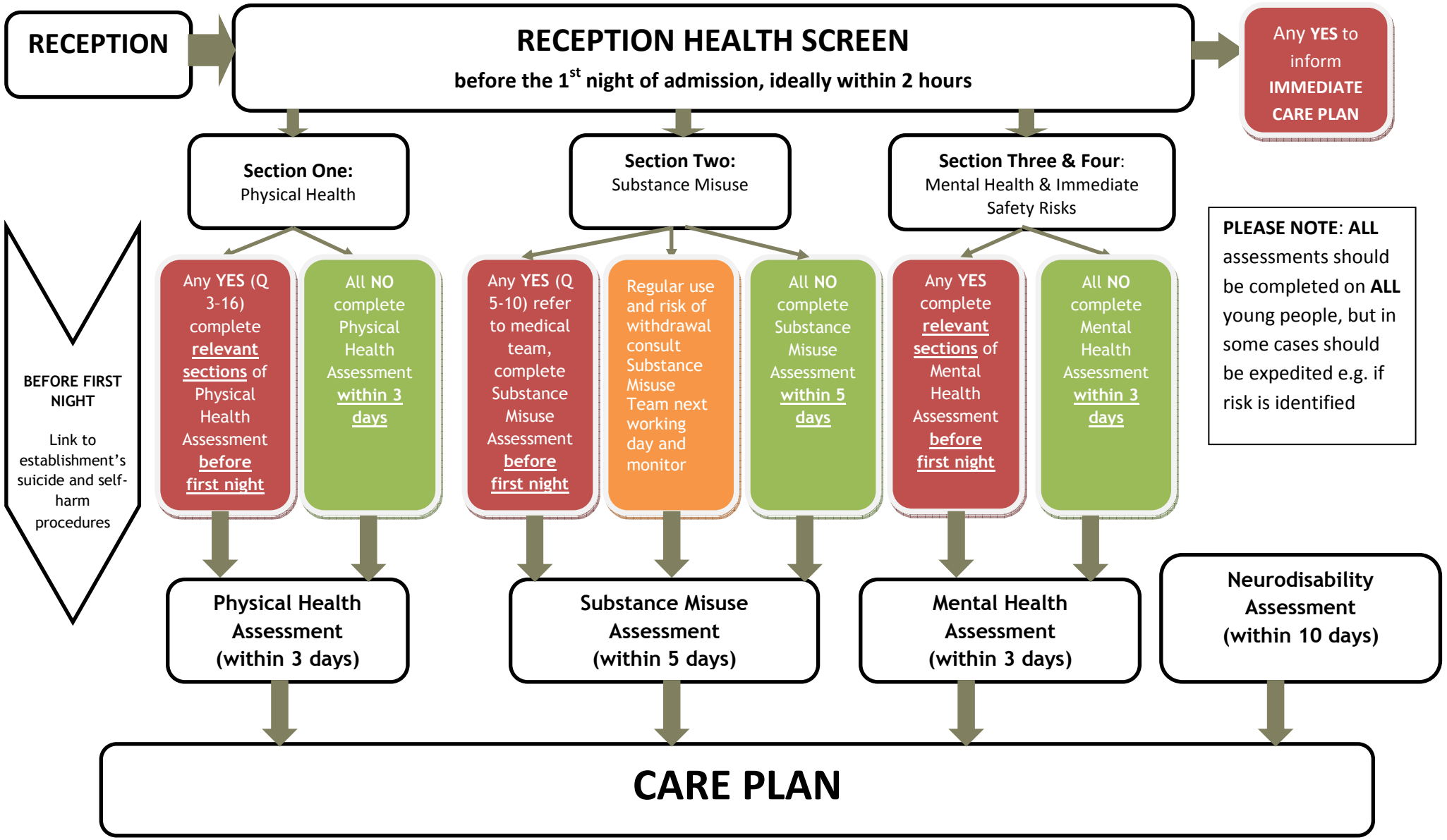
Substance Misuse Assessment – **within 5 days of admission**

Mental Health Assessment – **within 3 days of admission**

Neurodisability Assessment – **within 10 days of admission**

These are the **maximum** lengths of time within which to complete each part. Assessments can be completed in stages if this is easier for the young person but **MUST** be conducted earlier if any immediate health needs are highlighted from the Reception Health Screen.

Figure 1: How to Complete CHAT: the CHAT Pathway



4.2 Who should complete the CHAT

The **Reception Health Screen** is designed to be completed by a range of clinicians; including **Registered General Nurse (RGN), Registered Nurse (specialising in children; RNC) or Registered Mental Nurse (RMN)**.

The Physical Health, Substance Misuse, Mental Health and Neurodisability Assessments are more detailed comprehensive health assessments therefore designed to be completed by clinicians with the appropriate qualifications and training.

The **Physical Health Assessment** should be completed by nurses with either **RGN or RNC** level qualifications.

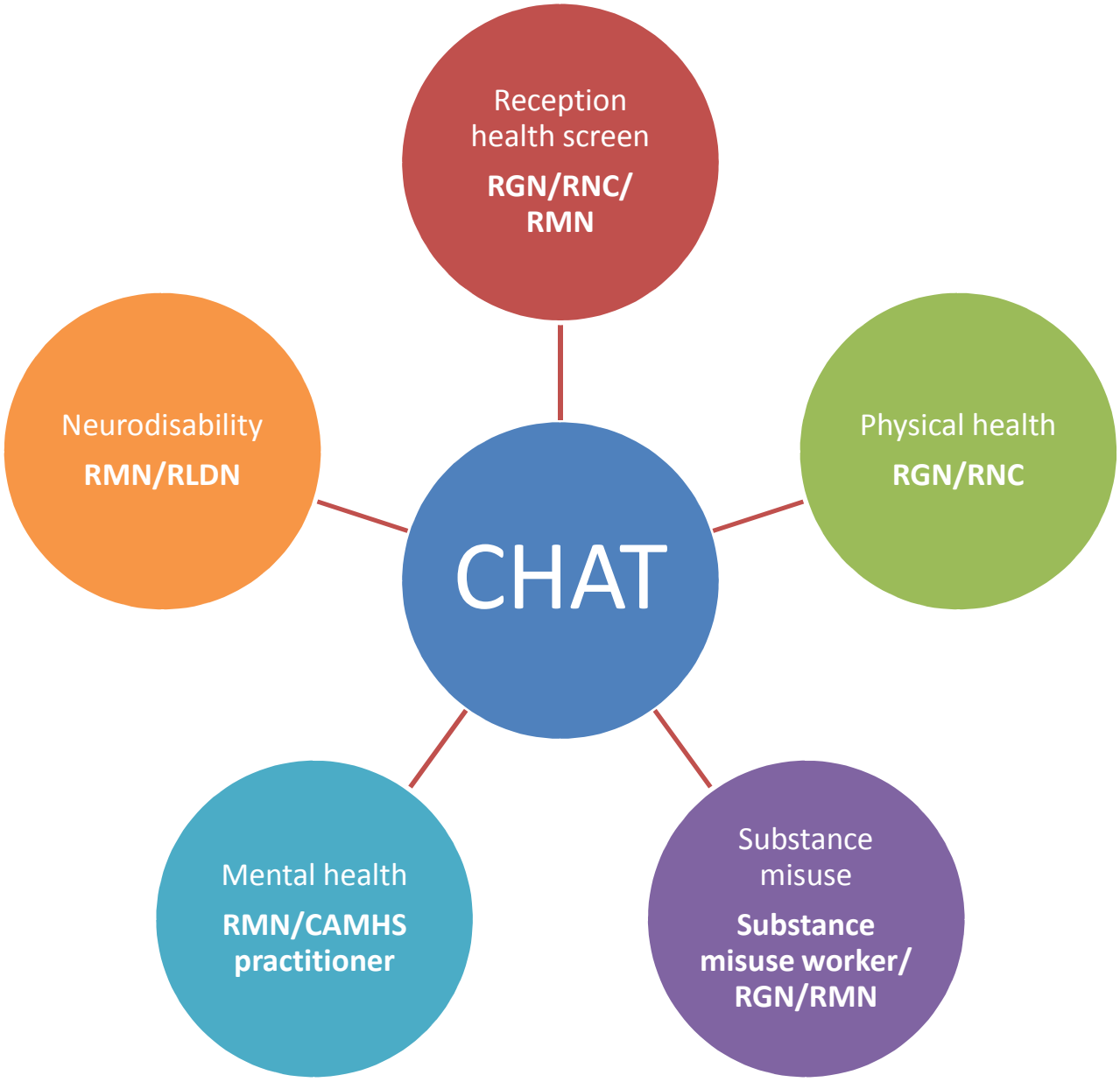
The **Substance Misuse Assessment** should be completed by staff with expertise in the assessment and treatment of young people with substance misuse problems, specifically a **substance misuse worker, RGN or RMN** (RGNs/RMNs may need additional training in substance misuse).

The **Mental Health Assessment** should be completed by nurses **with RMN level training or experienced Child and Adolescent Mental Health Services (CAMHS) practitioners**.

The **Neurodisability Assessment** should be completed by an **RMN or Registered Learning Disability Nurse (RLDN)**.

All staff working in the secure estate should be made aware of the CHAT and the CHAT pathway, although the assessments will be undertaken by clinical professionals. It is important that all key staff receive training in recognising health needs, e.g. signs of the onset of depression.

Figure 2: Professionals who should complete the CHAT



4.3 Optimising care and assessment

The CHAT is designed to support the work of experienced staff, and we recognise that professionals will apply their judgement to the process of engagement and assessment. When establishing a young person's history it is important to consider the strengths and protective factors of the young person in addition to risk factors.

4.3.1 Interview considerations

Please ensure that you have considered ALL the points below before beginning the CHAT:

- Ensure the interview room offers privacy, is quiet, comfortable and has access to all the appropriate equipment;

- Ascertain whether the young person's first language is English, and if necessary make use of local interpreter services;

- If the young person appears to have problems with communication or is difficult to engage in conversation, consider expediting the Neurodisability Assessment so that any modifications to assist communication can be utilised in the other CHAT assessments;

- If the young person presents as temporarily impaired e.g. by intoxication, medication, or injury, it may be necessary to stop and come back a few hours later when the person is not impaired to ensure accuracy of assessment. For those with language or learning difficulties continue with assessment but document concerns or difficulties. Also document any consistent modifications in language that are required for the young person to understand the assessment;

- Explain to the young person who you are and what your role is i.e. help identify any urgent health problems that require further attention or assess physical health;

- Explain what the CHAT is and that the process will continue over the next few days, and that this will result in a care plan, which the young person will be involved in developing;

- Explain that health information is confidential and is only shared with the persons responsible for the care and treatment of the young person unless the existence or likelihood of significant harm to the young person or other people is identified;

- Refer to '*When to share information – Best Practice Guidance for everyone working in the youth justice system'* (Department of Health 2008[1])

- Explain that if problems are identified, treatment may be offered and that the options, benefits and risks of each proposed treatment will be explained. Also explain that their permission or their parents'/legal guardian permission will be sought as appropriate. It is important to ascertain who has parental responsibility for a young person under the age of 18 years;

- Explain that it may be necessary to ask other people who know the young person for information, so that a complete health profile can be created. For example, if the young

[1] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084703

person is a Looked After Child (LAC), key information can be obtained from the Initial Health Assessment (IHA) for LAC);

- If the young person has spent time working with a Youth Offending Service (YOS), seek information from ASSET and other assessments, and insist on seeing accompanying medication and documentation.

4.3.2 Interviewing techniques

The following section highlights some important considerations:

Environment - The physical setting will affect the course of the interview. Comfort and privacy are essential. Rooms with multiple distractions and telephones ringing will lead to multiple breaks in the interview, which impairs the free flow and discussion of sensitive issues. Try and avoid physical barriers to the interview, for example talking across a desk makes the interviewer seem distant.

Safety issues - Be familiar with the layout of the room you are using including exits. Always try and position yourself nearest to an exit route. Trust your instincts – if you are beginning to feel uncomfortable or threatened by a young person, draw the interview to a close and leave.

Interviewing styles and verbal skills - While it is acknowledged that much of the CHAT involves direct questions, the guidance below may be useful if healthcare staff have to probe areas in more detail. This may be particularly relevant within the mental health sections. Research has been performed on how interviewers can optimise information obtained by the style of questioning adopted. In interviews several types of questions can be identified:

- Open questions are those that allow the individual to provide a wide range of answers. They give the opportunity for the young person to provide a description of their behaviour or feelings. For example: how are you feeling?

- Closed questions call for one of a limited set of responses – basically a yes or no answer, or a date, frequency, duration or other quite specific piece of information. For example: do you feel depressed?

Research on information gathering during interviews has shown that most factual information is collected when a systematic approach using open questions is used. However, closed questions can be useful when trying to fill in gaps in the information provided in response to open questions or for clarification. Some young people will agree to any closed questions and others will automatically avoid admitting to problems so be aware of not over using closed questions and of the need to verify answers. If open questions are well considered, a young person will often provide much of the needed information spontaneously.

- A leading question is one that directly suggests its answer; For example: I expect that made you feel angry, didn't it?

Suggestible individuals may feel pressure to comply and agree with the interviewer. Meanwhile an oppositional and defiant young person may seize the opportunity to demonstrate how wildly wrong the interviewer is, disregarding their actual feelings.

- A double question asks about two things at the same time and should not be used. For example: 'When the police stopped you, were you worried or angry, or didn't you care?'

These questions often draw a yes-no response but leave the interviewer unclear what the answer refers to.

- Multiple choice questions are a form of closed questions that may be helpful when regular open and closed questioning has failed to provide an adequate answer. For example: when asking about the frequency of thoughts of self harm and the young person says 'I don't know' a question like; 'Is it every day, once a week or a couple of times a month?' may be helpful.

However you need to consider the appropriate range of choices and further additional questions may need to be asked for clarification.

As many children and young people who offend have learning and language needs, it is advisable to use simple words and short sentences, constantly being alert for possible misunderstanding. The open question approach with its emphasis on getting the individual to describe their experiences and behaviour helps to ensure that both the interviewer and the interviewee are talking about the same thing. If you feel that you are not able to communicate effectively with the young person, this may well suggest that he or she has speech, language or communication difficulties. It is very important for you to seek assistance with completing the assessment. In the first instance discuss with your manager or supervisor.

It is important to pick up on spontaneous comments and reflect back information given by the young person. This not only aids in clarification of issues but also enhances the individual's sense of being listened to and understood. For example: 'You mentioned you've not been sleeping, can you tell me more about that?'

This creates more of an open dialogue, where the young person is more likely to give honest responses and elaborate on difficulties.

Sensitive issues - When asking about sensitive or potentially embarrassing areas like suicide and sexuality, a direct approach is favoured. Adolescents will pick up on the interviewers discomfort and are less likely to respond in an open and honest way.

Note taking - In long interviews when gathering information it is good practice to make notes on key issues as you go along. Always explain to the young person that is what you are doing. This avoids note taking becoming overtly intrusive. Recall following long interviews can be subject to much bias and important information can be lost or distorted if note taking is left until the interview is finished.

Listening and non-verbal skills - When talking to young people about mental health difficulties, sensitive techniques in asking questions are greatly enhanced by good listening skills in encouraging open and honest replies. Position yourself in the interview so you are turned towards the young person, conveying the message that you are engaged and interested in what they are saying. Avoid sitting directly face to face, as this can be perceived as confrontational.

The YJB are committed to equality and diversity with clear guidance relating to religious, sexual and gender identities (YJB, 2008). Sensitively obtaining accurate information can ease transition into the secure estate by providing additional support or monitoring for bullying.

4.3.3 Clinical Judgement

Screening tools seek to balance thoroughness and brevity. **They do not replace the need for clinical judgement.** For example, if a young person does not make eye contact, and is reluctant to answer questions about self-harm or suicide, it may be necessary to probe further. Furthermore, young people share different levels of information with people at different times. In this case it will be important to seek more information from other sources (e.g. care staff, teachers, parents/carers etc) or consider further assessment at a later date. Clearly this creates the potential for clinicians to gather conflicting information from two sources. Depending upon the nature of the information and any possible risk issues, clinicians may need to obtain guidance in supervision or discuss information with their line managers.

4.4 Completing the different parts of the CHAT

4.4.1 Gaining consent

The DH (2001) states that when deciding whether a person is capable of giving valid (informed) consent three main elements need to be considered. The person:

- Needs to be capable of making that particular decision (competent);
- Must be acting voluntarily – that is not being coerced; and
- Must be provided with sufficient information to enable them to make an informed decision.

Young people aged 16 and older are presumed in law to have capacity to give consent for themselves. Young people under 16 can give consent, but only if they are able to fully understand what is proposed.

The DH (2009) guidance states that:"Young people under 16 have a right to confidential medical advice and treatment if the provider assesses that:

- The young person understands the advice and has the maturity to understand what is involved;
- Their physical and/or mental health will suffer if they do not have treatment;
- It is in their best interest to be given such advice/treatment without parental consent;
- They will continue to put themselves at risk of harm if they do not have advice/ treatment; and
- They cannot be persuaded by the doctor/health professional to inform parental responsibility holder(s), nor allow the doctor/healthcare professional to inform them."

An assessment of 'capacity to consent' must be undertaken when a young person under the age of 16 does not want to involve parents/guardians. An assessment of capacity must also be established if young people are aged 16-17 and have learning difficulties or mental health issues.

Whether or not they are willing to participate in the assessment process, we would recommend that when young people under 16 do not want their parents to be contacted, staff should seek child protection advice from the local safeguarding children board. Where young people are over 16, they have a right to refuse parental involvement. However we would recommend that young people are encouraged to consider allowing staff to contact their parents, where appropriate as it may be helpful to understand why young people do not want their parents or carers involved.

An individual assessment of each young person should be made prior to commencing the CHAT, as capacity to consent can be influenced by a number of factors i.e. drugs and alcohol, medication, tiredness, anxiety etc.

There is a difference between consenting to the CHAT assessment and then consenting to treatment. Consenting to treatment should be done separately from the CHAT. Remember that young people may have the ability to consent to some procedures, but not others. Think about ways to help with understanding e.g. written information about the proposed treatment.

Ensure that the relevant sections of the CHAT assessment of capacity and consent form are completed every time a part of the CHAT is completed.

4.4.2 Reception Health Screen

The importance of reception screening is evident from both clinical practice and research. Shaw et al. (2004) found that 32% of suicides occurred within the first week of custody, with 11% occurring within the first 24 hours. Young people entering custody frequently have high levels of health needs and are also experiencing a profound process of adjustment. **The Reception Health Screen has been developed to identify those at serious risk of harm from physical health, mental health or substance misuse problems. It should be completed within 2 hours or before first night of admission**

Staff engaged in reception screening come from a range of nursing backgrounds and have different competency levels. However they will have developed a valuable resource of experience and skills in engaging and working with children and young people who offend. The CHAT seeks to supplement clinical judgement, and encourages people to employ established skills. This should be supplemented by reviewing previous assessments e.g. annual reviews of LAC, to identify established risks. Additionally, it is important to acknowledge the importance of gender and cultural factors. The CHAT and this manual should be supplemented by local diversity and cultural awareness training.

Important information in aiding assessment and identifying risk can also be gathered from other sources. However, children and young people who offend often do not have GPs or recent contact with primary care. Consequently, the observations made by professionals at reception may provide vital baseline information. Useful guidance on the assessment process can be found in the Royal College of Nursing (2011a) document *'Standards for assessing, measuring and monitoring vital signs in infants, children and young people'*.

Where young people appear difficult to communicate with, staff should ensure that arrangements are made to complete the neurodisability assessment of the CHAT as soon as possible. This will ensure that any communication issues that may impact the completion of the other sections of the CHAT are recognised as early in the assessment as possible.

4.4.2.1 *Physical Health*

Questions 3 – 16 of the physical health section of the Reception Health Screen are designed to identify potentially life-threatening or serious physical conditions e.g. diabetes. If a need is identified then complete **RELEVANT SECTIONS** of the Physical Health assessment **BEFORE** the first night and the remainder within **24 hours**. If no immediate needs are identified, complete the Physical Health assessment within **3 days**.

If the young person answers **YES** to **allergies** provide as much detail as possible including major reactions such as anaphylaxis and minor reaction and incorporate into care plan.

If the young person reports **breathing problems** but these are due to upper respiratory tract infections or problems such as a runny nose do not include here.

If the young person reports that they have **diabetes** ask the young person if it is treated by diet, tablets or insulin (i.e. insulin dependent versus non-insulin dependent).

When completing the Reception Health Screen look for any discolouration or **rashes** on the skin, these may be indicative of communicable infection but do not include acne, eczema, or sweat rashes.

Look for any signs of **trauma** and be aware that the young person may attempt to cover-up any injuries sustained during custody or en route to custody (establish if a safeguarding referral is needed).

Record if the young person has **medication** or a **disability aid** which is being retained in the young person's possession.

For females always offer a **pregnancy** test and if the young person tests **positive** they must be seen by doctor prior to first night and incorporate this into care plan.

Record any physical health problems identified that could be exacerbated by restraint.

4.4.2.2 *Substance Misuse*

If the young person answers **YES** to any **questions 5 – 10** in the substance misuse section and is showing signs of withdrawal symptoms then discuss their immediate clinical management with a member of the clinical team (doctor or nurse) **BEFORE** the first night. The Substance Misuse assessment should subsequently be completed within **24 hours** to allow for a more detailed assessment of the young person's substance misuse problems.

When completing the Reception Health Screen you will be referred to a range of withdrawal rating scales, which can help with determining physical dependence. If the young person is using alcohol or substances regularly (every day within the last month) and/or previously experienced withdrawal symptoms, include closer monitoring for withdrawal symptoms in the CHAT Immediate Care Plan. Additionally, discuss with the substance misuse team next working day whether the substance misuse assessment should be completed sooner. Otherwise complete the Substance Misuse assessment within **5 days**.

Alcohol use: if there is regular recent use then complete AUDIT–PC. If they score 20 or above on AUDIT-PC, arrange for immediate examination by a clinical team member e.g. nausea & vomiting; sweating; tachycardia; insomnia; agitated and restless; anxious; can't sleep; hallucinations; grand mal seizures (*use your observational skills*). If showing active signs of withdrawal, arrange for immediate examination by a clinical team member, and monitor with Clinical Institute Withdrawal Assessment (CIWA-Ar).

Look for signs of **Benzodiazepine** use e.g. nausea & vomiting; malaise; flushing & sweating; tachycardia; hyper-ventilating; panic attacks and/or phobias; over-excitable and/or aggressive; shaking/trembling; coarse tremor in hands, tongue and eyelids; insomnia; grand mal seizures. (*use your observational skills*). If showing active signs of withdrawal arrange for immediate examination by a clinical team member and monitor with Clinical Institute Withdrawal Assessment (CIWA-B).

Look for signs of **Opiate use** e.g. tachycardia; sweating; restlessness; pupillary dilation, runny eyes; muscle aches; runny nose and sneezing; abdominal pain; tremors and twitches; frequent yawning; anxiety or irritability; prominent gooseflesh (*use your observational skills*). If showing active signs of withdrawal arrange for immediate examination by a clinical team member and monitor with an opioid withdrawal scale (for instance, the Clinical Opiate Withdrawal Scale (COWS).

Look for signs of **Cannabis** use e.g. anxiety; irritability; tremor; sweating and muscle pains (use your observational skills).

Look for signs of **Stimulant** use, and ask about use including amphetamines e.g. lethargy; craving; increased appetite; insomnia and bizarre or unpleasant dreams (*use your observational skills*). Be aware that young people reporting recent heavy stimulant use and whose urine/oral fluid tests are positive for stimulants require management in a setting that has a 24-hour registered nursing presence. This includes general observation and monitoring of blood pressure for signs of hypertension and neurological observations, for the first 72 hours of custody.

If you are planning to offer medication for substance use, note that a clinical drugs test must be completed and the result recorded prior to any prescribed management.

4.4.2.3 *Mental Health*

If a young person answers **YES** to any of the questions entitled 'Mental Health Concerns' or 'Immediate Safety Risks' in the Reception Health Screen, complete the **RELEVANT SECTIONS** of the Mental Health assessment **BEFORE** the first night and the remainder within **24 hours**. Consider heightened observation and use local self-harm/suicide prevention procedures until the Mental Health assessment has been completed. As noted previously, young people who self-harm are at increased risk of completed suicide, thus if evidence of deliberate self-harm is noted, then local suicide prevention procedures should be implemented.

If the initial Reception Health Screen indicates a medium to high risk of self-harm or suicide, complete all relevant sections of the Mental Health assessment and implement local self-harm-suicide prevention procedures.

Finally, information from the CHAT will need to be fed into local pathways. New staff will need to access local inductions to understand referral routes into specialist services both for urgent and routine assessments, e.g. when referring young people for an urgent mental health assessment.

Look for any signs of **unusual speech**, especially if the young person is using words and phrases in an odd or bizarre way e.g. jumbled words/disjointed or rapid speech.

Ascertain if the young person demonstrates evidence of any **delusional beliefs**, i.e. fixed, firm beliefs without foundation in reality. Assess whether the young person is experiencing hallucinations e.g. responding to visual or auditory hallucinations during the assessment *(responding to voices when there is nobody there)*.

Look for signs of **depression** e.g. low in mood, withdrawn; slowed down in responses to questions.

Look for signs that the young person has particular **risk** factors for self-harm or suicide e.g. warnings arising from ASSET such as bereavement, family mental illness; concerns raised by escorting officers or previous establishments; safeguarding or child protection issues e.g. being subject to a child protection plan and a longer than expected sentence. Ensure that all staff are up-to-date with suicide and self-harm procedures.

Any YES identified on the Reception Health Screen should inform the CHAT Immediate Care Plan

4.4.3 Physical Health Assessment

This section should be completed by qualified health staff, for example a suitably qualified Nurse Practitioner (RNC or RGN) within **3 days** of admission, and supplemented by a physical examination undertaken by a medical or nursing professional. It will be important to examine both the previously completed sections of the CHAT e.g. Reception Health Screen and other relevant documents, such as documentation relating to LAC. These will inform the final CHAT Care Plan. ***Note that children and young people who offend may previously have been LAC even if they no longer have this status, thus it would be helpful to check for Social Care records.***

The Physical Health assessment provides a framework for the systematic assessment of physical health and social circumstances of the young person. The tool identifies care and treatment opportunities, for example identifying missed immunisations, and untreated health conditions such as STI. Health needs can also change while young people are in secure accommodation, for example they might develop an exacerbation of asthma. In these circumstances it would be important to repeat the relevant sections of the physical health assessment, but unless otherwise indicated, the CHAT should be repeated on an annual basis during the course of the sentence. Finally, if there is any evidence of non-accidental injuries, then local safeguarding procedures should be activated.

Young people in contact with the YJS may not have had regular access to primary care, and entry into secure care can provide an opportunity to meet their health needs. Obtaining baseline pulse and blood pressure can flag up a current illness and can also be used in later assessments to refer back to; a low body mass index (BMI) might lead to a greater focus on the examination of the gastrointestinal system; while gait abnormalities might suggest underlying musculoskeletal/neurological problems or current drug/alcohol use.

Obtaining a detailed past medical and medication history can ensure treatment is not interrupted and highlight problems that might recur during the young person's stay in secure accommodation. Young people can provide valuable information about their health, for example problems such as sickle cell or thalassaemia. The Royal College of Nursing (2011b) has a useful document, written with service user involvement, which details consequences of sickle cell and thalassaemia. Remember that sickle cell is a condition that affects red blood cells; causing them to deform into a 'sickle cell' shape and silt up in blood vessels which can be very painful.

4.4.3.1 *Cardio-Vascular System*

Young people in the contact with the YJS have a number of cardio-vascular risk factors including smoking, poor diet and lack of exercise. Cardiovascular risk factors are important in young people. This is evidenced by research showing that a higher BMI during childhood is associated with an increased risk of Coronary Heart Disease in adulthood (Baker et al., 2007). **Pulse and blood pressure readings can provide important information as to whether further assessment is required. A rapid pulse in conjunction with a history of trauma (consider shock or infection) can be concerning. Finding cyanosis might be suggestive of an underlying cardiac abnormality.**

Anxiety can exacerbate or present as cardio-vascular symptoms. Does the young person have any abnormalities in their vital signs? *(take the radial pulse, rhythm, volume, wave; check blood pressure; signs of bulging vessels; digit clubbing; oedema; peripheral cyanosis; and deep vein thrombosis)***.**

4.4.3.2 *Respiratory System*

Studies assessing young people in contact with the YJS have highlighted the high number of young people with chronic physical health needs such as asthma (Butler et al., 2008). For many these difficulties may be undiagnosed, while for others non-compliance with treatment or difficulties accessing primary care services may be common. Observation for physical signs of respiratory distress e.g. laboured or fast breathing is essential to enable prompt treatment of concerning respiratory conditions such as pneumonia or acute exacerbations of asthma. **Observe the respiratory rate (remember vital signs are age related); look for unusual rise and fall of chest; flared nostrils; laboured breathing; cyanosis. Observe whether the young person has a cough, if they expectorate, examine the sputum type: colour or evidence of blood. Also listen to their breathing, look for evidence of rattling or wheezing.**

Listen for tightness of breath; expiratory wheeze; when does it occur; does anything exacerbate it; type of treatment e.g. inhaler.

4.4.3.3 *Tuberculosis Screening*

Tuberculosis (TB) is a highly infectious disease. Young people who have been previously homeless, have a history of substance misuse, originate from high risk ethnic minority populations or have recently visited key countries for more than one month are at increased risk. National Institute for Health and Clinical Excellence (NICE) emphasises the importance of screening for TB while in the secure estate and recommends that healthcare workers providing care for prisoners and remand centre detainees should be aware of the signs and symptoms of active TB (NICE, 2011a). TB services should ensure that awareness of these signs and symptoms is also promoted among children and young people who offend and prison staff. **Children and young people should be screened for TB by:**

- **A health questionnaire on each entry to the prison system; and then**
- **For those with signs and symptoms of active TB, a chest X-ray, and three sputum samples taken in 24 hours for TB microscopy, including a morning sputum sample.**

4.4.3.4 *Gastrointestinal System*

Gastrointestinal disorders are common in adolescents. Chronic abdominal pain, lactose intolerance, constipation, and irritable bowel syndrome represent the most common gastrointestinal complaints, while inflammatory bowel disease is the major chronic disorder of concern to clinicians (Pleskow et al., 1991). **Questions addressing gastrointestinal symptoms such as bowel habit and history of abdominal pain could suggest these diagnoses. Questions addressing symptoms of vomiting might give rise to concerns about withdrawal symptoms and perhaps peptic ulcer disease/gastritis. They may also prompt disclosure of an eating disorder.**

4.4.3.5 *Eyes, Hearing and Oral Health*

Young people in the YJS may have unrecognised visual and hearing needs. This can impact on engagement with education and the young person's ability to access offence related work. **Where hearing problems are evident, the CHAT neurodisability assessment should be initiated as soon as possible because hearing problems are often associated with communication difficulties.** Furthermore, young people are unlikely to have visited the dentist and often have poor oral hygiene.

4.4.3.6 *Genito-Urinary System and Sexual Health*

Young people in the YJS are more likely to engage in risky behaviours such as sexually promiscuous behaviour. Almost 1 in 5 were found to have STI including Chlamydia and Gonorrhoea (Golzari et al., 2006). These disorders are more common in young people in the YJS as they are more likely to become sexually active younger, have multiple partners and less likely to use condoms. Providing sexual health information on the impact of untreated STI and communicable diseases on the young person's health and possible treatment options is therefore important. **Young people may be experiencing sexual exploitation, it is important that young people are given several opportunities to disclose information.**

Questions about contraception also provide an opportunity to educate young people and to encourage them to access contraceptive services in the future as teenage pregnancy rates in the UK are currently the highest in Europe (Family Planning Association, 2010).

When asking about sensitive or potentially embarrassing areas like sexuality, a direct approach is favoured. Adolescents will pick up on the interviewers discomfort and are less likely to respond in an open and honest way.

4.4.3.7 *Endocrine System*

The more common endocrine problems in adolescents are diabetes and thyroid abnormalities. **It is worth noting that abnormalities in height or delayed onset of puberty may not have been previously identified and thus need further investigation.** It is important to acknowledge that there are wide variations in the "norm" for such values as height and that someone who appears very short for their age might have familial short stature. It is hoped that diabetes will have been identified in the Reception Health Screen, particularly if insulin dependent (type 1 diabetes). We acknowledge that Type 2 diabetes is less common in this age group.

Thyroid Dysfunction should be excluded by looking for physical changes (e.g. distortion of the shape of the neck; protruding eyes; significantly over or underweight; hair loss or tachycardia) or behaviour changes (e.g. presenting as over-excited with excessive fidgeting or under-active and labile with slow speech and thought).

4.4.3.8 *Musculo-Skeletal System*

The high risk behaviours of many young people who offend can increase the risk of musculo-skeletal injuries through fighting and accidents. Furthermore, chaotic lifestyles of young people and their families may mean that they do not always attend follow-up appointments or access treatment for fractures. **Young people may present with symptoms of inflammatory arthritis. Bony abnormalities may suggest chronic health problems or vitamin deficiencies such as rickets. Musculoskeletal pain in young people should always be taken seriously and assessed with careful attention to detail; compared to an adult, back pain in children is more likely to have a serious underlying disorder.**

4.4.3.9 *Nervous System*

Headaches, epilepsy and head injuries are common neurological problems in young people. The assessment might enable management of treatable conditions such as migraine and perhaps reduce the seizure frequency of someone with poorly controlled epilepsy.

In practice it is hoped that the different sections of the CHAT will enhance and supplement one another. For example, if a young person is identified as undergoing substance misuse withdrawal in the Reception Health Screen, they may become disorientated during the process of withdrawal. Similarly, young people who have experienced head injuries may suffer memory loss or

headaches. Alfstad et al. (2011) identified that youths with epilepsy were more likely to engage in risk taking behaviour, including substance misuse, fighting and burglary. **Ensure that young people are orientated in time, place and person; ensure that they know the date, time and place *(remember responses will be age related)*. Further information about the young person's memory and orientation can be ascertained by asking where the young person lives; by returning to a question the young person answered before, or by checking whether the young person can remember your name *(remember responses will be age related).***

Once the Physical Health assessment has been completed go back through the assessment with the young person and reiterate the problems and issues that you have identified and the proposed actions (such as gathering further information, undertaking further tests, medical examination, initiating care and treatment). Explain for each of the proposed actions the possible risks, benefits and implications of not proceeding and ensure that the young person understands. Ask the young person for their views on the proposed action and request consent where necessary.

4.4.4 Substance Misuse Assessment

Good practice suggests that substance misuse screening should be done as soon as possible after concerns are raised. This part of the CHAT should be completed within **5 days** of admission, by a substance misuse worker, RGN or RMN.

Physical withdrawal from substances can be life threatening as well as distressing. Delirium tremens occurs in just less than 5% of individuals withdrawing from alcohol. The syndrome usually starts 48 to 72 hours after cessation of drinking and is characterised by coarse tremor, agitation, fever, tachycardia, profound confusion, delusions and hallucinations. Convulsions may highlight the onset of the syndrome but are not part of the symptom complex. Hyperpyrexia, ketoacidosis and circulatory collapse may develop (NICE, 2011b).

Minor degrees of alcohol withdrawal are commonly encountered and individuals can be managed without specific treatment. However, people with moderate or severe alcohol withdrawal symptoms often require sedation to prevent exhaustion and injury.

Evidence of physical dependence should always be sought because of the management implications. **Symptoms of early morning retching, tremor, anxiety and irritability, ingestion of alcohol before midday, amnesia and "blackouts" are all suggestive.** A history of previous withdrawal seizures and the development of delirium tremens clearly indicate a history of dependence.

Thus as noted in the screening section, supplementary tools should be considered. Formal guidance is provided (Gilvarry & Britton, 2009) *"Establishing clear evidence of substance use is required prior to prescribing any substitute medication. Therefore a drug toxicology test should be undertaken, though a positive result does not necessarily denote dependence."* A range of withdrawal rating scales are available that can help with determining physical dependence, including:

- Clinical Opiate Withdrawal Scale (COWS) (Wesson & Ling, 2003)
- Clinical Institute Assessment of Withdrawal – Benzodiazepines (CIAW-B) (in Baillie & Mattick, 1996)
- Clinical Institute Withdrawal Assessment – Alcohol (CIWA-Ar) (Knott, et al, 1981; Wiehl, et al 1994; Sullivan, et al, 1989)

It is important to note that the guidance emphasises that tools provide a supplement to clinical judgement. Furthermore, all of these tools were developed on adults, not young people and therefore may have some limitations.

When conducting the assessment, practitioners should review all information about substance use and misuse within the context of addressing concerns around child protection/safeguarding. Refer to the appropriate local guidance regarding safeguarding, and if necessary obtain guidance from the local named nurse or doctor. Furthermore, seek guidance from your line manager regarding practitioner responsibilities if it becomes apparent that substance use/misuse or (in particular) injecting use is only happening in the company of an older individual. Finally, when ascertaining how the young person funds their substance use, practitioners should remain alert to the risk of sexual exploitation, and provide a further opportunity for disclosure.

The comprehensive list of all substances has been compiled after extensive consultation. Complete all sections as accurately as possible as this information will be key when considering possible regimes relating to withdrawal e.g. from opiates.

Currently there is an emphasis on universal, targeted and specialist provision within the delivery of substance misuse services within the secure estate. The 2012 guiding principles for

transferring commissioning responsibility from the YJB to local partnership areas discusses the need for a joint care planned approach supported by multi disciplinary meetings (YJB, 2012). This document also notes that the timely identification and assessment of substance misuse needs to be aligned to wider health assessments:

1. Substance specific targeted interventions including preventative harm reduction advice and information and brief interventions;
2. Specialist interventions including group work provision and one-to-one psychosocial interventions jointly care planned for those young people accessing additional support to manage broader multiple needs;
3. Detoxification and pharmacological management or arrangements to respond to clinical need where identified aligned to the delivery of ongoing psychosocial support and;
4. A comprehensive process of through-care and resettlement support to support continuity of care on release from the secure establishment.

Within the secure estate, certain aspects of substance misuse treatment such as initial screening are undertaken by healthcare staff. Substance misuse workers will offer targeted substance misuse support, and any psychosocial interventions. Substance misuse workers will also have a role in brokering any prescribing required with local GPs or psychiatrists. There is a need for care co-ordination and for joint care planning and robust information sharing between substance misuse workers and healthcare to ensure a consistency of approach and to prevent duplication.

Once the Substance Misuse assessment has been completed go back through the assessment form, jointly with the young person to determine how they view the antecedents, behaviours and consequences in relation to their substance use. Ascertain their motivation to make changes in their lifestyle and other factors to stop, reduce use or minimise harm related to substance misuse. Reiterate the problems and issues that you have identified and the proposed actions (such as gathering further information; undertaking further tests, medical examination, initiating care and treatment). Explain for each of the proposed actions the possible risks, benefits and implications of not proceeding and ensure that the young person understands. Ask the young person for their views on the proposed action and request consent were necessary.

4.4.5 Mental Health Assessment

This part of the CHAT provides a framework for the systematic assessment of mental health needs within the secure estate to identify care and treatment opportunities. It should be completed within **3 days** of admission, by an RMN. Specific points of relevance include previously detected learning difficulties which may impact on a young person's ability to communicate mental health needs.

As noted previously, the process of entering the secure estate can cause a young person's mental health to deteriorate (Kroll et al., 2002). **Therefore it is recommended that this section be reviewed for all young people three months after admission for any information that may indicate that this section need to be repeated.** All staff should be trained to look for signs suggesting there is deterioration in a young person's presentation, or evidence of self-harm. As with all clinical assessments, the mental state of the young person and information from other sources should also be incorporated into the assessment, as they are important sources of information. There need to be clear pathways for accessing both routine and urgent mental health assessments. Finally, where necessary, staff should be able to access specialist consultation and supervision.

4.4.5.1 *Depression*

Rates of depression among children and young people who offend are higher than in the general population of the same age. Furthermore depression in adolescents may not always present with the typical symptoms associated with this illness. **It is important to sensitively ascertain the young person's experience of depression e.g. irritability, reduced motivation and enjoyment in activities. Such questions should be supplemented by exploration of other biological symptoms of depression e.g. reduced sleep and appetite. Feelings of guilt or hopeless may indicate an increased risk of self-harm, and should prompt increased levels of monitoring and supervision.** Clinicians are advised to discuss therapeutic options in supervision and consider referral for a specialist mental health assessment.

The questions in the CHAT comprise a mix of the biological symptoms of depression e.g. reduced sleep and appetite and questions relating to depressive cognitions, e.g. guilt. **The experience and expertise of RMNs is important and clinicians are encouraged to use their existing methods of eliciting clinical information.** Untreated depression is a risk factor for self-harm and completed suicide in young offenders as with adults.

4.4.5.2 *Deliberate Self-Harm*

There is literature to suggest that young people may harm themselves indirectly as well as directly e.g. causing fights, getting drunk and allowing themselves to become vulnerable sexually. The NICE (2011c) guidance on self-harm provides information on assessment and management. Working with people who self-harm can be emotionally demanding, it advises that staff should be offered supervision. The guidance advises that where possible people should be seen by staff of the same gender, and that each act of self-harm should be assessed fully, exploring the reasons for each new act. Clinicians are advised to discuss therapeutic options in supervision, and consider referral for a specialist mental health assessment if concerned about the risk to the young person. It is acknowledged that young people who self-harm are increased risk of suicide.

4.4.5.3 *Suicide Risk Factors*

As noted previously, young people in custody are at increased risk of completed suicide, thus in addition to the clinical risk factors such as depression and self-harm, the very experience of custody is a risk factor. **Changes in circumstances such as recent bereavement or loss,**

significant dates such as anniversaries, relationship breakdown, and further sentences accrued while in custody and peer interactions should all be monitored.

4.4.5.4 *Anxiety*

Anxiety "*is a feeling of unease such as worry or fear that can be mild or severe*". Helpful definitions can be found on the Royal College of Psychiatrists website[2] which notes that the experience of anxiety in threatening situations is normal. However, when people experience anxiety in a range of other situations, it can impact on their functioning. **The mental symptoms of anxiety include: worry; struggling to concentrate; irritability; low mood. The physical symptoms include: struggling to sleep; fast or irregular heartbeats; dry mouth; fast breathing; pallor; dizziness; nausea; indigestion and diarrhoea.**

Generalised Anxiety Disorder (GAD) is a long-term condition which causes a person to feel anxious about a wide range of situations and issues, rather than one specific event, and a key feature of this condition is the fact that the anxiety is present for much of the time.

Panic attacks are episodes of intense anxiety, while these often occur in situations which are likely to cause anxiety, they are unpredictable, and start suddenly, usually reaching a peak in about 10 minutes. People report that they are short of breath, and feel as if they are going to die or go mad. A quarter of people attending Accident & Emergency with concerns about a heart attack, are experiencing a panic attack (See Royal College of Psychiatrists website[3]). Regardless of their involvement with the YJS, it may not always be obvious when young people are anxious, for example they may present with irritability or restlessness.

4.4.5.5 *Post-Traumatic Stress Disorder (PTSD)*

Frightening events, which are beyond an individual's control, can happen to anyone, and many people recover fully. However for some people, traumatic experiences trigger a reaction, which can lead to PTSD. Examples of trauma include sexual abuse, bullying, accidents, and witnessing harm to another person. In the latter case the sufferer may be the person who caused the injury or a peer who was with them. People with PTSD find that they are reliving the experience through flashbacks in the day and nightmares at night. Children and young people who engage in high risk activities e.g. stealing cars, breaking into people's houses or getting into fights are at risk due to exposure to trauma. Additionally, data from the Offending, Crime and Justice Survey found that young people in contact with the YJS were themselves twice as likely as their peers to be the victim of crime (Roe & Ashe, 2008).

4.4.5.6 *Psychosis*

Psychosis can be described as losing the ability to distinguish between reality and the experiences inside one's own mind. Symptoms of psychosis include hearing voices that other people cannot hear. This abnormal perception, which is not based in reality, is known as a hallucination. Hallucinations can affect any of the senses, although auditory hallucinations are most common. Other symptoms of psychosis include thought interference e.g. having unusual thoughts that other people do not seem to have, feeling controlled by a force or power outside oneself, that appears to be controlling one's thoughts or actions, worrying that someone is putting or removing thoughts from one's head. People experiencing psychosis can report feeling that some people are too interested in them or trying to hurt them; also known as paranoia. They can also report feeling as though they have special powers. Such abnormal beliefs are known as delusions, and it is important to understand a person's cultural context, as religious beliefs can be a core part of a person's cognitions without indicating any illness.

[2] www.rcpsych.ac.uk/expertadvice/problems/anxietyphobias.aspx
[3] www.rcpsych.ac.uk/expertadvice/problems/anxietyphobias/anxiety,panic,phobias.aspx.

Psychosis can indicate that a person has **schizophrenia.** Therefore it is important to look for other accompanying symptoms or changes in functioning such as reduced self-care, social isolation and poorer academic and occupational functioning.

Psychosis can also be a part of **bipolar affective disorder.** Other symptoms of this disorder include a previous depressive episode, and the person becoming manic in their presentation; very excited, irritable, not sleeping, having lots of energy and becoming disinhibited. In this illness, the symptoms of psychosis are often in keeping with the person's elated state of mind e.g. they may think they have a lot of money or have special powers.

Psychosis can be associated with **substance misuse**, e.g. a person may be paranoid or experiencing auditory hallucinations when they have taken cocaine or cannabis. Visual hallucinations, can be a symptom of alcohol withdrawal. As noted earlier, alcohol withdrawal can have serious physical consequences, and when a young person reports visual hallucinations, it will be important to check that they are orientated in time, place and person.

With psychosis clinicians are advised to discuss making an urgent referral for a specialist mental health assessment. These symptoms of psychosis may be related to drug misuse or underlying mental illness such as schizophrenia or bipolar affective disorder.

4.4.5.7 *Attention Deficit Hyperactivity Disorder (Hyperkinetic Disorder)*

ADHD is a diagnostic term from the Diagnostic and Statistical Manual of Mental Disorders Version 4 (DSM-IV) and is characterised by three core symptoms of hyperactivity, inattention and impulsivity. This term is synonymous with the term Hyperkinetic Disorder from Version 10 of the International Classification of Diseases (ICD-10). Although ICD-10 is the diagnostic system most commonly used in the UK, the term ADHD has become widely known. DSM-IV notes that these symptoms are displayed more frequently and present with more severity than peers of the same age. This developmental distinction is important to note, as levels of activity in a 15 year old with learning disabilities will be higher than activity levels in someone without learning disabilities. At the present time DSM-IV requires that the clinician find evidence that symptoms have been present since before the age of 7. Thus NICE (2008) guidance on ADHD notes that when assessing older adolescents or adults for undiagnosed ADHD, it is important to try to get an informant history e.g. from a parent, carer or if at all possible a teacher. DSM-IV also notes that the symptoms have to be present for at least 6 months and present in more than one setting, e.g. education and the clinical setting. In girls the presenting feature can be attentional problems (Young et al., 2005). **Children with ADHD are more likely to have communication difficulties, so where ADHD is suspected, the neurodisability assessment should be initiated as soon as possible**.

ADHD may be difficult to diagnose reliably as it can often occur with other conditions such as learning disability or can be difficult to distinguish from attachment problems, which are both more common in offenders compared with the general population. The concept of attachment; the relationship between child and carer was first described by Bowlby (Bretherton, 1992). There are a number of different attachment styles; secure, insecure-ambivalent, insecure-anxious/avoidant and disorganised. Rogers et al. (2004) summarises the way relationship patterns can exacerbate risk and vulnerability in adolescence. Insecure-Ambivalent attachments can be characterised by impulsivity, disruptive behaviour, aggression and poor concentration. When working with LAC children, **it can be difficult to unpick whether behaviour is due to attachment or ADHD and thus referral for a specialist assessment may be required**.

4.4.5.8 *Eating Disorders*

The ICD-10 defines anorexia nervosa as "*characterised by deliberate weight loss, induced or sustained by the patient*". Traditionally anorexia was most commonly seen in teenage girls. The NICE guidance (2004) suggests a ratio of about 10:1 for females and males in relation to both anorexia and bulimia nervosa. Diagnostic criteria include maintenance of body weight at 15% below that expected by avoiding fattening foods e.g. by excessive exercise, diet or purging. There is an associated body image distortion with a persistent fear of fatness and usually results in a disordered hormonal picture with a loss of the menstrual cycle in women and a loss of sexual interest and potency in men.

Bulima nervosa is described by ICD-10 as "*characterised by repeated bouts of overeating and an excessive preoccupation with the control of body weight, leading the patient to adopt extreme measures so as to mitigate the 'fattening' effects of digested food*." Such measures include vomiting and laxatives. ICD-10 reports that bulimia often follows anorexia. Clinicians are advised to discuss therapeutic options in supervision, and consider referral for a specialist mental health assessment. There is a gender ratio of 19:1 for females to males in the prevalence of Bulimia. Cortese et al. (2007) note that ADHD is over-represented in people with Bulimia, given the over-representation of ADHD in the criminal justice system, **it is hypothesised that bulimia may be over-represented in female offenders**. Look out for signs of vomiting e.g. calluses on the hands, dental decay and sores around the mouth.

Once the Mental Health assessment has been completed go back through the assessment form with the young person and reiterate the problems and issues that you have identified and the proposed actions (such as gathering further information; undertaking further tests; medical examination; initiating care and treatment). Explain for each of the proposed actions the possible risks, benefits and implications of not proceeding and ensure that the young person understands. Ask the young person for their views on the proposed action and request consent.

4.4.6 Neurodisability Assessment

This part of the CHAT should be completed within **10 days** of admission but should be **expedited if concerns are raised about a young person's level of understanding and/or communication difficulties.** Prior to interview with the young person, review their notes and discuss their presentation and functioning with their parents/carers and other professionals who know them well to obtain any relevant information. Look for any evidence of special schooling, school difficulties/exclusions, early developmental problems, head injuries or reports that may indicate learning disability, speech and language or social communication difficulties (ASD). Assessment findings must be considered in the context of the young person's wider needs and also in relation to their age. **More caution should be applied when interpreting assessment findings for a younger age group e.g. for those under 14 years in the Speech Language and Communication Impairment section.** As young people who offend commonly present with needs in multiple domains, it is essential that assessment findings are discussed in the context of the young person's wider needs through access to regular supervision and consultation.

4.4.6.1 *Traumatic Brain Injury*

The tool used in this section was developed from the Rivermead Postconcussion Symptom Questionnaire (King et al., 1995) with kind permission from the author. **TBI occurs when the head receives a severe blow or jolt, for example in an accident, fall or assault, causing the brain to be damaged.** There are other forms of acquired brain injury (ABI) which may have been caused by a stroke, haemorrhage, infection, hypoxic/anoxic brain injury and medical accidents. These are not included here, but check whether the young person has experienced any of these as they may influence the young person's presentation.

The severity of TBI can be measured in different ways. It is routine to first assess the depth of LoC based upon the extent to which a patient is able to respond to stimuli. The duration of post-traumatic amnesia can also be used to denote the severity of the injury. This is the length of time after the injury that the person is alert but cannot recall the event. The most commonly used measure in research is the length of time for which an individual is unconscious following the injury. Whilst there is variation in the definitions of different categories, commonly a **minor injury is classified as an injury resulting in a LoC of 5 to 10 minutes or less. Mild injuries are those with a LoC of between 10 and 30 minutes. Moderate are those with LoC of 30 minutes to 1 hour and severe anything above an hour.**

Young people will usually remember a head injury, even if they are unable to provide clear information about the details or consequences. It may be helpful to use the prompts suggested in the tool such as the context of the head injury (e.g. during boxing, fighting or road traffic accident) to try to trigger a memory and use additional cues to ascertain the potential severity, e.g. was an ambulance called, did they go to hospital and were they admitted for observation. Try to ascertain how many times the young person has had TBIs, and whether they received medical attention (include details such as physical examination only, or also an X-ray or scan of the brain).

Work through the table looking at the different ways in which a young person might be injured, and whether or not they lost consciousness. When completing the table on symptoms experienced following the accident, **make it clear that you are asking the young person to talk about the period of time <u>since</u> the accident and also include any objective information regarding a change in functioning at this time.**

The tool has been developed to identify young people with possible moderate to severe head injuries (LoC>30 minutes) and postconcussional symptoms that require further

specialist assessment. Review the young person's medical records and CHAT Physical Health assessment and where possible obtain information from a parent or carer. This can be particularly important when asking about head injuries that may have occurred when the young person was a small child. **If there is evidence to suggest that a TBI has occurred, discuss whether a more detailed medical assessment is initially required to clarify the need for a paediatric or neurology specialist assessment. Persistent symptoms for three months following a head injury requires further assessment and investigation, a recent head injury also requires medical advice.**

With young people identified with mild to moderate impairment, consider the impact of their symptoms on their daily living skills and occupational functioning and include practical strategies within their care plan. For example, when communicating provide short clear information and try to limit background noise. Use visual cues where possible and allow the young person sufficient time to process the information. Help the young person develop coping strategies around their particular areas of deficit e.g. poor social or organisational skills. Staff can access additional information on strategies through the Disabilities Foundation website[4] or training via the Child Brain Injury Trust[5]. There is also useful information for young people via the Child Brain Injury Trust[6]

4.4.6.2 *Speech, Language and Communication Impairment*

Communication disorders relate to problems with speech, language and hearing that significantly impact upon an individual's academic achievement or day-to-day social interactions. This incorporates a wide range of conditions. Problems with speech include aspects of dysfluency, such as stammering, speech impediments and articulation difficulties. Language impairments may relate to the expression (expressive impairment) or comprehension (receptive impairment) of words during communication or the pragmatic (social) use of language. This might include form, content or function of language and can result in social communication difficulties. Communication disorders can be secondary to hearing loss, or problematic auditory processing of information, such as an inability to recognise subtle differences in the sound of words. Communication disorders are typically first observed and diagnosed during childhood or adolescence and, whilst some may be related to developmental delay, others may persist into adulthood. Therefore, information from a parent or carer regarding the young person's early developmental history and functioning can be helpful, including access to previous speech and language therapy.

Many young people who offend have problems with speech, language and communication that have not been previously identified. Bryan et al. (2007) suggests that at least 60% of young offenders have these difficulties, which are often overshadowed by their challenging behaviour. Also these young people may have developed coping strategies to manage, for example developing stereotyped or stock answers to questions. It is important to remember that a young person may have difficulties understanding speech or written instructions. They may be able to understand speech and writing, but may have difficulties forming words in their head or with the actual process of speech. Remember that the severity of these problems can vary, and can be exacerbated by anxiety or tiredness. These difficulties can impact on daily functioning, including engaging in education and offence related work.

The narrative task in the CHAT has been validated with young people within the YJS. **The task aims to assess whether a young person can provide a coherent account of an activity with the information given in the correct order.**

[4] www.tdf.org.uk/
[5] www.childbraininjurytrust.org.uk/
[6] http://youthzone.childbraininjurytrust.org.uk/index.html

Ask the young person to explain how to do one of the following activities: Setting up a table to start a game of pool; Making a cheese sandwich; Putting on a DVD to watch; Choosing and playing an X-box/Play station game; Buying something to eat from a café, shop or fast food place. If none of the examples seem appropriate let the young person talk through the stages of an activity of their own choice. Also if they rush the task give prompts to encourage them to give more detail. The pool example has been validated on a sample of male and females aged 14-18 years within a YOT (Gregory & Bryan, 2011; Burrows & Yiga, 2011).

Example answers for Narrative Task:

a) Setting up a table to start a game of pool
Get the balls and put them on the pool table. Put the coloured balls in the triangle and then remove the triangle. Put the white ball on the spot/ top of the table and hit the white ball with the cue into the coloured balls.

b) Making a cheese sandwich
Cut 2 slices of bread from a loaf or take 2 slices of bread from the packet and put them on a plate. Open the fridge and get out the cheese and the butter/margarine. Use a knife to spread the butter on the bread. Then cut a few slices of cheese and put them on one slice of bread on top of the margarine. Put the other slice with the butter facing down on top of it. Then cut it in half.

c) Putting on a DVD
Turn on the DVD player (and the TV if watching through that). Take the DVD from its box. Use the remote or press the button to open the DVD drawer. Put the DVD onto the drawer and press the button again so it goes back in. Press 'play' on the remote and then select/choose what you'd like to watch.

d) Choosing and playing an X box or Play station game
Turn on the TV and Xbox. Choose a game and take it out for its box. Use the controller or press the button on the X box to open the (X Box) disc tray. Put the game into the tray/drawer and press the button again so it goes back in. Select the right TV channel with the TV remote. Use the controller to select the game, what level you are at and other options. Then start the game.

e) Buying something to eat from a fast food place, café or shop (give examples of what is local to the young person e.g. McDonalds, Greggs)
Make sure you have some money. Go into the shop/café. Decide what to buy by looking at what is on the menu or on display. Check that you have enough money and go to the counter. Ask for what you would like, give enough money and take any change that's given back. Wait for your food and then eat it

If the young person fails in only one area then repeat the task using another example. If you still have concerns following the second task discuss the assessment findings with a member of the mental health team or Speech and Language Therapist. If the only part the young person struggled with was using longer/complex sentences check this out by doing another example or noting if they have used longer/complex sentences elsewhere in the assessment. Again if you still have concerns discuss with the team.

The final part of this section incorporates informant history (parent or carer) as well as information from observation during the course of the assessment. Note any communication difficulties during the assessment, and speak to staff working with the young person as they may have highlighted concerns about the young person's expressive or receptive (comprehension) language skills.

It can be difficult to ascertain whether a young person has communication difficulties. **If a communication difficulty is suspected discuss the assessment findings with a member of the mental health team, in the context of the young person's age and wider needs (e.g. learning and mental health needs) as well as current functioning.** It would be helpful to seek consultation from the local speech and language therapy team to identify young people who require further assessment and intervention, either while the young person is in the secure estate or on release. Information regarding identified difficulties should be included within the care plan with recommended strategies to support the young person e.g. informing staff working with the young person about appropriate communication style.

4.4.6.3 *Learning Disability and Educational Needs*

Many young people who offend will have educational needs secondary to learning, emotional and behavioural difficulties including a range of neurodevelopmental disorders. A smaller subgroup of young people may have a learning disability or a specific learning difficulty which is important to differentiate to access appropriate support.

The British Psychological Society (BPS; 2000) suggest that the definition of a learning disability should include three criteria:

- significant impairment of intellectual functioning, typically measured as an IQ score of less than 70;
- significant impairment of adaptive or social functioning, identifiable through difficulties with everyday tasks such as household tasks, socialising or managing money; and
- onset prior to adulthood.

Whilst a person's IQ can fluctuate in the stages of their development, the other criteria are such that a learning disability is only identified if there is childhood onset and persistent concerns with adaptive functioning. Learning disability is therefore a broad term, incorporating several aspects of functioning that might impact on day-to-day living, including one's ability to learn, to understand complex tasks, or to interact with others.

The diagnosis of a learning disability requires all three of the above criteria to be present; however, the degree of disability is commonly classified into four categories on the basis of IQ, as defined by the World Health Organisation;

- Mild - where a person's IQ is between 50 and 69;
- Moderate - where a person's IQ is between 35 and 49;
- Severe - where a person's IQ is between 20 and 34; and
- Profound, where a person's IQ is less than 20.

Distinct from a classification of learning disability are a range of specific learning difficulties. Whereas a learning disability implies a global developmental delay, a learning difficulty is a specific difficulty in the context of an individual's intelligence and therefore often relative to their IQ. Thus, a young person with a specific learning difficulty may be of average or above average intelligence. The young person may therefore not have their difficulty immediately recognised, yet performance in particular aspects of their education may not match this level of intelligence in

one or more specific areas. Within the current ICD-10 and DSM-IV manuals, specific learning difficulties are classified as relating to:

- **Reading**: difficulties with word recognition, the processing of phonetics, reading rate or comprehension. This is the most common learning difficulty. Whilst a range of reading-related learning difficulties are apparent, the term is often seen as synonymous with dyslexia.
- **Written expression**: frequent errors in grammar and punctuation, poor paragraph structure, excessive spelling errors, and poor handwriting. Again, various specific difficulties exist, though learning difficulties with writing are often referred to as dysgraphia.
- **Mathematics**: difficulty undertaking calculations, understanding concepts such as quantity, or time, or understanding and manipulating numbers. The generic term often used for such learning difficulties is dyscalculia.

For the assessment, try to use a room with a large clock, or if necessary use a wrist watch (non-digital) and have ready access to an appropriate magazine to read. Many children and young people may have struggled with the school process. The initial questions within this section are to ascertain whether the young person has any learning or educational needs. Allocation of support is an indication that the young person was assessed as having some degree of difficulty. Attending a special school may indicate that the young person has experienced significant emotional or behavioural or learning difficulties, although it is helpful to clarify the nature of the educational placement, for example specialist behavioural/pupil referral unit or specialist school for children with learning disabilities. Contact with specialist learning disability services within the community is likely to indicate that the young person has at least a moderate learning disability. Speak to parents and carers and liaise with key worker/personal officer and education staff for further information.

The subsequent questions focus on the young person's functioning and daily living skills which are often impaired among young people with a generalised learning disability. In addition to asking young people questions regarding their independent functioning, it is also important to obtain corroborating information from informants (e.g. key worker, personal officer or parent/carer). Some young people may have specific difficulties with reading comprehension which may be hidden. **When asking the young people to read a paragraph from the magazine, make sure that it is an appropriate topic (consider age, gender and cultural factors). Additionally, ask them one or two questions about the content of the paragraph to ascertain whether they have understood the information.**

The assessment of vulnerability will be enhanced by information from parents/carers, key worker or educational staff. However, information can also be gained from objective assessment of the young person (e.g. presents as socially naive for age) and by asking the young person about their patterns of friendships e.g. 'always making new friends, but does not really see the old ones'. Note if the young person has had to modify their language excessively or if they struggle to remember things without prompts.

This section of the CHAT aims to identify young people with learning difficulties as well as broader educational needs. It is important to identify young people with a learning disability to ensure that they can access appropriate support. If a need is identified discus with education staff for further specialist assessment or further screening can be undertaken using the Child and Adolescent Intellectual Disability Screening Questionnaire (CAIDS; McKenzie et al, 2012) which demonstrates good reliability and validity in identifying young people with a learning disability.

4.4.6.4 *Autistic Spectrum Disorders*

NICE (2011d) notes that *"The term "autism" describes qualitative differences and impairments in: reciprocal social interaction (e.g. to and fro social interaction and use of body language), social communication (e.g. engaging in to and fro conversation, initiation of talking and interest in other peoples experiences), combined with restricted interests (a narrow range or very strong interests), rigid and repetitive behaviours (e.g. repetitive routines, difficulty being interrupted or a need to finish a task or topic of talk) and sensory sensitivity e.g. disliking loud or sudden noises)"*. The guidance also notes that core *"autism behaviours are typically present in early childhood, but are not always apparent until the circumstances of the child or young person change, for example when the child goes to nursery or primary school or moves to secondary school"*. **Autism is strongly associated with a number of coexisting conditions, including learning disability which may complicate the assessment and management process.**

Social communication difficulties can be on a spectrum and therefore the term ASD or Autistic Spectrum Condition (ASC) is often increasingly used. ASD/ASC includes; Autism, Aspergers Syndrome and Pervasive Developmental Disorder (PDD).

People with Pragmatic language impairment (PLI) have problems with the semantic aspect of language (the meaning of what is being said) and the pragmatics of language (using language appropriately in social situations) and therefore often present with social communication difficulties.

If the young person has previously been assessed and diagnosed with an ASD, this information should be incorporated into the young person's care plan. Each young person will have a unique profile of impairment which will impact on their functioning so it is helpful to obtain copies of previous assessments as they can describe the young person's particular profile of need, for example with conversational skills, difficulties with empathy or sensory sensitivity to noise.

The questions used in the tool were developed from the NICE guidance and clinical practice (NICE, 2011d). **Use your experience to make the distinction between young people who are different from their peers.** Use developmentally appropriate comparisons e.g. consider whether they are socially immature due to learning difficulties or social anxiety. **Look for other factors that may indicate difficulties e.g. involvement in unusual crimes**. **It is important to get an informant history as parents can provide information about the young person's early developmental history including social development and a family history may indicate increased genetic vulnerability.** Also speak to staff working with the young person as they may have indicated possible social communication difficulties, such as the young person being socially awkward, difficulties in engaging in to and fro conversation, or having obsessive or unusual interests.

It is useful to start by having a conversation with the young person about their family and friends and what they enjoy doing. **Use open questions and allow plenty of time for them to answer. Use prompts that show you are interested to ask for more information e.g. can you say a bit more about X. Then change the conversation to a different topic of your choosing for example telling them about your interests and experiences e.g. a previous holiday or pet and assess if the young person can follow your topic and shows interest in your experiences by asking additional questions.**

When assessing the young person, note features of the young person's language skills e.g. speaking in a monotonous voice, taking things literally or talking repetitively about their own particular interests. If there are silences, do they seem uncomfortable and does the conversation flow reciprocally (to and fro). When assessing social interactions, look to see whether the young person interrupts you, or cannot be stopped when talking about specific subjects.

When asking about friendships, it can be helpful to ask the young person the names of friends and what makes someone a best friend. A young person with an ASD may for example list all the names of young people in their wing with no clear understanding of the reciprocal nature of a close confiding relationship. Ask their key worker or personal officer if the young person is avoided or possibly bullied/teased by peers. During the session, observe the young person's body language including eye contact and facial expressions to ascertain whether they seem appropriate.

When assessing routines, ask staff working with the young person if they struggle with changes in their routine or are unusually inflexible and rigid in their views. Also ascertain whether they share their peer's interest in music or hobbies, or display less interest in their hair or other personal attributes. Finally, does the young person display an unusual or excessive reaction to particular sensory stimuli (e.g. touch, sound, smell or taste)? For example do they respond negatively to loud noises such as alarms or bells?

If there is evidence of social communication difficulties, discuss with a member of the mental health team. It may be agreed that further screening and assessment is required for possible ASD by using standardised assessment tool such as the Social Responsiveness Scale (Constantino, 2002) or Social Communication Questionnaire (see NICE Guidelines, 2011d).

Once the Neurodisability assessment has been completed go back through the assessment form with the young person and reiterate the problems and issues that you have identified and the proposed actions (such as gathering further information and undertaking further assessment). Explain for each of the proposed actions the possible risks, benefits and implications of not proceeding and ensure that the young person understands. Ask the young person for their views on the proposed action and request consent.

4.5 Care Planning

4.5.1 CHAT Immediate Care Plan

Any **YES** identified on the Reception Health Screen should inform the CHAT Immediate Care Plan and should be completed within 2 hours or before the first night of admission (the CHAT Immediate Care Plan is located at the end of the Reception Health Screen). Record all problems identified and what actions will need to take place. The care plan asks for details of who is going to be responsible for these actions and a review time and date, it is anticipated that this will allow staff to take ownership of the relevant tasks. Also include here any health problems that may increase vulnerability during a restraint. Ensure that information in the Immediate Care Plan is communicated with all staff involved in the care of the young person as soon as possible.

4.5.2 CHAT Care Plan

Completion of all the CHAT sections (e.g. physical health, mental health, substance misuse and neurodisability) over the following few days will allow for a comprehensive health care plan for the young person to be created. Each professional completing the CHAT assessment will contribute to the same CHAT Care Plan this ensures that the young person receives a consistent and holistic approach to their needs throughout their time within the secure estate. It is essential that professionals who complete each section of the CHAT include in the care plan a summary of all the health needs identified as this allows for important information to be shared with all staff working with the young person. Regularly review and update the CHAT Care Plan as required.

The Care Programme Approach (CPA) has been in use since 1990 and provides a framework for the effective coordination and support of care for people with serious mental illness in secondary services. Many of the principles are relevant for young people with mental health problems, to quote from the Department for Work and Pensions *"multi-agency support, active engagement, intensive intervention, support with dual diagnoses"* as well as support for those *"who are at higher risk."*

4.5.3 Discharge/Transfer Planning

The importance of discharge planning is illustrated by the Harrington et al. (2005) study which found that needs increased when young people were released into the community. NOMS issued guidance effective from 3.12.12 stating that all young people released from YOIs will be supervised for 3 months. Supervision can be provided by a social worker from a local authority or a YOS. This needs to be viewed alongside the guidance from the YJB 'Leaving custody or secure accommodation'[7], which notes that young people who are in secure settings are vulnerable to homelessness, and may spend longer in secure settings because no suitable community accommodation can be provided for them. Post-discharge care for young people can be limited in all areas (Harrington et al., 2005). Therefore it is important that professionals working with young people's needs and services are advocated for at a commissioning level. Without a discharge address it is difficult to register with a GP, without a GP it is difficult to obtain seamless primary care and to access mental health service, particularly when transitioning into adult care.

The CHAT Discharge/Transfer Plan identifies a 'responsible person', which prompts clinicians to identify professionals who will be responsible for a young person's ongoing care in the community e.g. nurse practitioner who will be delivering ongoing ADHD care.

[7] www.justice.gov.uk/youth-justice/accommodation/leaving-custody-or-secure-accommodation

The CHAT Discharge/Transfer Plan contains summary sections of current and previous health concerns. It is hoped that this will provide a channel for information sharing between services, ensuring that identified needs which have not been fully addressed in the secure estate can be communicated with community services.

We are aware that adolescents in the secure estate can undergo many transitions; from secure to community settings, through different community settings if they are LAC or become homeless, and entering adult services when they reach the age of 18. Furthermore, young people serving short orders may be released before detailed assessments prompted by the CHAT have been completed. The YJB (2010a) document '*National Standards for Youth Justice Services'* states that the "*supervising officer must provide the secure establishment from which the young person was discharged with an end of sentence report incorporating their education, training and employment performance as laid down in the National Specification for Learning and Skills*." We would recommend that health professionals involved in completing the CHAT and those involved in the young person's subsequent care are fully involved in the young person's discharge planning. Note – National Standards are due to be updated in 2013.

It is good practice that <u>ALL</u> young people, regardless of whether they have been in the secure estate previously or transferred from another establishment complete the Reception Health Screen on admission.

If a young person has been in the secure estate previously or transferred, ensure that previous CHAT assessments and CHAT Discharge/Transfer Plans are obtained as soon as possible. Needs constantly change so the CHAT and CHAT Care Plan will need to be reviewed and/or updated on transfer/re-admission.

4.6 When to repeat the assessment following admission

Needs constantly change so the CHAT should be reviewed if a new health need is identified. For example if staff note that a young person is withdrawn or isolating themselves, they should be advised to request a repeat mental health assessment. If no new needs are identified, it is recommended that the CHAT assessments are repeated annually after the first review.

Young people who have been using substances may have changing needs in the hours and days after admission, including withdrawal symptoms. The majority of these young people should have been identified through the Substance Misuse assessment. However ongoing training of staff within the secure estate in signs of drug misuse is essential.

Three months into the young person's secure admission, there should be a review of the Mental Health assessment and the team should record whether they have decided to repeat the assessment or not.

Research suggests mental health needs may increase during this period (Kroll et al., 2002). However, as noted by Mitchell and Shaw (2011), mental health needs can change quickly. Thus in line with current practice in some parts of the secure estate e.g. HMP&YOI Hindley it is recommended that a short term follow-up (2–4 weeks following admission) is provided for any young people perceived as vulnerable or struggling to adjust to custody. These young people may be identified by the Risk Assessment and Management Form. Furthermore, if deliberate self-harm is identified and/or noted for any young person, the young person should be referred for a further mental health assessment due to the high risk of suicide among individuals who are known to self-harm.

The CHAT Neurodisability assessment should be reviewed if there is any new information following admission e.g. if the young person sustains a head injury or if learning or social communication needs become more apparent. If communication difficulties become apparent during the assessment, the CHAT should be reviewed. Specifically if a young person has learning difficulties, they may not have understood some of the questions or have had the information that was needed e.g. diseases previously contracted. Alternately, if a young person has an undiagnosed ASD they may not have been able to communicate their feelings or experiences of anxiety.

4.7 Developing local pathways

Successful implementation of the CHAT as a health screening and assessment tool requires it to be embedded within local pathways with access to specialist consultation and assessment for young people. This will require commitment and commissioning support from local partner agencies. Young people with identified needs should have timely access to the full range of evidence based interventions available.

The implementation of the CHAT should ensure timely screening and assessment of young people in the secure estate following admission, with opportunities to observe and engage the young person. The CHAT should also ensure that staff access corroborative and informant history. It is acknowledged that it may be difficult to achieve a full assessment in some groups, for example those on remand who may be transferred or released with little notice. Turner and Marks (2012) identified the challenges in developing an assessment service for ASD within a secure setting, noting that young people with short sentences may not have their assessments completed. It is anticipated that the neurodisability assessment within the CHAT will ensure that concerns regarding developmental disorders can be recorded and communicated clearly to community settings or other secure placements to ensure more detailed assessment is completed as required.

Staff should have access to regular supervision to establish which young people would benefit from further assessment or intervention. For example young people with learning disabilities often have other difficulties e.g. episodes of low mood may complicate both the assessment and intervention process and therefore access to specialist consultation is essential. In order to effectively implement the CHAT, there needs to be ownership and ongoing commitment both from the local multi-agency network and the relevant commissioning structures. Ongoing professional development of key staff is recognised as a vital part of this process.

It is acknowledged that each secure establishment will have specialist knowledge of key partner agencies and provision. For successful implementation, the CHAT should be imbedded within local pathways. This includes appropriate training for staff, clinical supervision and clear routes for further specialist consultation or assessment.

4.8 Training and supervision

A supervisee is a practitioner who receives professional advice, support and guidance from a supervisor. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting suggests that clinical supervision enables the supervisee to develop greater knowledge and a deeper understanding of accountability and clinical governance frameworks. For those practitioners who are very experienced in their field of work, a supervisor may be used as a source of support for reflection on practice.

Clinical supervision allows a registered nurse, mental health practitioner or substance misuse worker or comparable professional, to receive professional supervision in the workplace by a skilled supervisor. It allows clinicians to develop their skills and knowledge and helps them to improve care. Clinical supervision enables clinicians to:

- Identify solutions to problems;
- Increase understanding of professional issues;
- Improve standards of patient care;
- Further develop their skills and knowledge in assessment and management of young people with health needs; and
- Enhance their understanding of their own practice;

The Royal College of Nursing document *'Clinical supervision - how and why?'* (2006) offers the following guidance:

- Determine the frequency and length of meetings; the frequency and length of meetings should be dependent on its purpose and format for example allowing at least 2 hours if this is in a group format to allow for meaningful discussion.
- Clarify the role for supervisors; this is likely to include coordination of sessions, establishing and maintaining ground rules, establishing a 'safe' environment, facilitation of the process, documentation, summary and action planning;
- Identify potential supervisors and determine training needs ;
- Supervisors need to be skilled and experienced practitioners; they must be good listeners with ability to provide constructive feedback and be open and tolerant of others;
- Establish a method for supervising the supervisors;
- Supervisors may have to provide considerable emotional support and take on board issues that cause concern or anxiety. It is therefore essential for the supervisors to be able to receive support and debriefing in a formal way.

There are various models or approaches to clinical supervision; one-to-one supervision, group supervision, peer group supervision. The choice of approach will depend upon a number of factors, including personal choice, access to supervision, length of experience, qualifications, availability of supervisory groups, etc. The Royal College of Nursing (2002) document on supervision and Clinical Governance emphasises the need for robust frameworks; ongoing audit cycles, reflective practice and processes whereby training needs are addressed through reflective practice and ongoing continuing professional development.

A supervisor is a skilled professional who assists practitioners in the development of their skills, e.g. clinical or managerial, their knowledge and professional values. A supervisor, in this instance, is a qualified practitioner who has sufficient experience to deploy advice in a supervisory situation. Supervisors may be line managers, or colleagues, who are in a position to counsel staff on practice guidelines and applied policy.

Ensure that both parties are aware of the clinical governance and confidentiality structures available within all partnership organisations, and that arrangements around information sharing have been agreed before supervision starts. Typically, supervisors would support clinicians to develop skills around recognising key conditions, for example anxiety or depression. Staff would learn how to manage health needs where appropriate and when to refer cases on for more specialist assessment.

4.8.1 Clinical Judgement and training

Training and personal development are ongoing processes. Supervision may enable clinicians to identify areas of potential growth, for example undertaking nurse prescribing courses or gaining Cognitive Behavioural Therapy (CBT) training through the programme of Improving Access to Psychological Therapies (IAPT). The identification of training needs can be usefully linked to regular appraisal processes. Furthermore, staff members can develop their clinical and managerial skills through internal departmental training, online approved courses or external training.

4.8.2 Training secure estate staff

The majority of young people will have only limited contact with the healthcare team during their assessment. Thus is it essential that all staff will be able to recognise possible symptoms of ill health (mental, physical, substance misuse related, developmental). For example social withdrawal (consider depression or psychosis) or refusing food (depression, eating disorder, psychosis, autism, gastric problems).

Staff should be made aware of any existing physical or mental health problem, and individual care plans should offer guidance on signs and symptoms that suggest conditions are deteriorating. Staff should also be made aware of physical health problems that are over-represented in this population, for example dental disease, asthma and STI.

4.8.3 Clinical Governance

Clinical governance is the process of examining current practice and considering ways in which systems and practice can be improved. The CHAT should be used alongside local clinical governance guidance and audit programmes. The NICE website[8] provides audit tools for individual disorder areas e.g. ADHD. It is recommended that departments develop local audit protocols and guidelines based on national standards. Audit is a way of examining local practice and comparing it with best practice. There needs to be an overall audit vision and pathway to ensure that departments are examining areas which are challenging as well as areas which are personally interesting.

As well as examining areas such as conformity with standards around the assessment and diagnosis of ASD, audit can be an opportunity for user involvement, e.g. satisfaction with the health assessment process.

[8] www.nice.org.uk

5 Additional guidance to support the CHAT

5.1 Looked After Children

Young people can become looked after children in two ways; firstly they can become accommodated under s.20 of the Children Act 1989 or become the subject of a care order under s.31 of the Children Act 1989. Under s.20, people under 16 can be accommodated with the consent of those with parental responsibility, while those of 16 or 17 years of age can consent themselves. Furthermore, the local authority can provide accommodation to anyone of 16 - 21 years in a community home if they believe it necessary to safeguard or promote that young person's welfare.

Any person with parental responsibility for a child may remove adolescents from accommodation at any time. If the young person is 16 or 17 years old, they can leave the accommodation without parental consent.

The local authority or any authorised person can apply to the court for a child or young person to become the subject of a care order. Care orders are made by the court and when an application is made, the local authority must prepare a care plan for the future of the young person. Adolescents can also enter the LAC system through an emergency protection order (s. 44 of the Children Act 1989).

If a child or young person who is in care by virtue of s.20 is sentenced to custody, they will cease to be looked after, but the local authority will still have specific duties to visit them while in custody and will also hold information on file about their health and wellbeing, (see The Children Act 1989 Regulations and Guidance: Local Authority responsibility towards former looked after children in custody 2010[9]).

Note that all children and young people remanded to custody will become looked after children for the period of the remand s.104 Legal Aid, Sentencing and Punishment of Offenders Act (LASPOA) 2012. If they were not looked after before being remanded, the CHAT Assessment will be the LAC health assessment.

While it is good practice to involve young people in all decisions about their care, there are occasions where parental consent can be valuable. For LAC, consent can be obtained from parents if appropriate, however it can also be obtained from the body/person holding parental responsibility e.g. the social worker or social work manager. With regard to health needs this group of young people are considered to be particularly vulnerable and new evidence has become available on the extent and nature of health problems among LAC (Department for Education, 2011).

The additional challenges faced by LAC, such as discord within their own families, frequent changes of home or school, and lack of access to support and advice from trusted adult's impact on the way they will react to a secure environment. Longer-term outcomes for LAC remain worse than their peers (NICE, 2010). It is important to note that children and young people who offend may have been looked after, or subject to a child protection plan, in the past. Furthermore, young people who leave home at 16 owing to family disruption may have many similar needs without the protection of LAC status. The Designated Nurse and doctor for LAC may be a source of helpful health and background information about young people.

[9] www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-00562-2010

Before any young person receives a health assessment, it is essential to bring together as much relevant information as possible and this information should be fast-tracked to the health professional undertaking the assessment. For LAC, sources of information include:

- Children's services assessments undertaken in accordance with the Assessment Framework e.g. the child's personal history and family history if it is known;
- the health assessment undertaken when children enter care, and the annual assessment from a nurse practitioner and doctor. The initial assessment is recorded on the IHA;
- community dental services or family dentist records;
- community health services;
- the child health computer system, particularly for immunisation status;
- the GP record;
- local Accident and Emergency departments;
- local hospital record systems, especially where the child is known to have been in contact with services; and
- contact with child and adolescent mental health services.

On discharge from the secure estate steps should be taken to fast-track the records to any GP with whom the child is known to have subsequently become registered (this should be done by the Clinical Commissioning Group of the previous GP).

5.2 Safeguarding children

The National Service Framework for Children, Young People and Maternity Services (DH & DfE, 2004) establishes clear standards for promoting the health and well-being of children and young people and for providing high quality services which meet their needs. Within this framework all agencies are required to work together; to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed. Central to the ethos of safeguarding legislation is the concept that safeguarding is a proactive process unlike the older concept of child protection. Thus all staff working with all young people in the YJS have a responsibility to uphold this principle. Furthermore, Sherlock (2004) notes that young people in custody are more likely to have children of their own.

The Children Act 2004 (s.10 and 11) and the statutory guidance in Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children (HM Government, 2010) requires all agencies to work together to prevent children suffering harm and to promote their welfare, to safeguard children who are being or are likely to be harmed and to provide them with the services they require to address their identified needs.. Central to the ethos of safeguarding legislation is the concept that safeguarding is a proactive process unlike the older concept of child protection. Thus all staff working with all young people in the YJS have a responsibility to uphold this principle. Furthermore, Sherlock (2004) notes that young people in custody are more likely to have children of their own.

All professionals working directly with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of all elements of the care they offer. Any professional who comes into contact with children, parents and carers in the course of their work also needs to be aware of their safeguarding responsibilities. All health professionals are required to recognise risk factors and contribute to reviews, enquiries and child protection plans, as well as planning support for children and providing ongoing promotional and preventative support through proactive work.

Governors/managers of all secure establishments should have in place arrangements that protect the public from young people in their care. All young people who have been identified as presenting a risk of harm to children will not be allowed contact with them unless a favourable risk assessment has been undertaken by the police, probation, prison and children's social care services. Governors/managers of women's establishments with Mother and Baby Units need to ensure that staff based on such units are prioritised for child protection training. Governors/managers of YOIs are required to adhere to the policies, agreed by the Prison Service and the YJB, for safeguarding and promoting the welfare of children held in custody. Secure Training Centres (STCs) house vulnerable, sentenced and remanded young people aged between 12 and 17 years. Each STC has a duty to safeguard and promote the welfare of the children in its custody.

Thus when completing the CHAT immediate care plan, it is important to consider the safeguarding implications both in regard to the risks posed by the young person and any risks that they are vulnerable to. The YJB guidance in relation to Multi-Agency Public Protection Arrangements (MAPPA, YJB 2010b) emphasises the need to identify serious and violent sexual offenders, share information about them and develop plans that enable best use of available resources.

5.2.1 Information Sharing

The Children's Commissioner (2011) report *'I think I must have been born bad'* offers clear guidance on information sharing. "*Professionals from all disciplines working with children whether detained or in the community, should have a shared understanding, delivered through joint training, of key factors affecting child and adolescent health and wellbeing including child and adolescent development, attachment theory, resilience factors and children's rights so that they are competent to work with children in all settings. This would encourage and promote shared working between community-based mainstream services and those provided to children in custody and improve information sharing on admission, whilst in detention and when planning good transitions on exit*."

The report also notes the need for robust protocols "*between the Ministry of Justice, Department of Health, and Department for Education and local government in relation to sharing health, education and social care information about children and young people in the youth justice system*."

This was also highlighted in *'When to share information; Best practice guidance for everyone working in the youth justice system'* (DH, 2008). "*Reports into the deaths of young people in the secure estate highlight the importance of good information-sharing practice. A lack of communication has been a constant theme in reviews and investigations*."

5.2.2 Sharing with consent

Under certain conditions, information given in confidence may be disclosed (or shared or passed on). Most commonly, this happens because the person who gave the information consents to it being passed on, understands what is to be passed on, to whom, and for what purpose.

5.2.3 Sharing without consent

Where consent to share is not given, or cannot be obtained, information may still be disclosed and in some circumstances it **should** be disclosed. There is no specific legislation setting out the circumstances that justify disclosing confidential information without consent. However, some people have complained to the courts about breaches of confidentiality and this has led to the courts setting out some basic principles based on these individual cases. These principles have informed the guidance issued through professional codes of practice, which specify, for instance, that disclosure can be justified in the public interest or to help address serious crime. Explain to young people what the information will be used for, and the contexts in which it will be shared. As some young people will have undetected communication problems, it is important to check that they have understood what is meant by information sharing.

Codes of practice specify that the starting point is for professionals to be clear about the reason for wanting to disclose information without consent. They also need to think about the implications of not disclosing information, including the possibility of the child being at risk of harm or causing harm to others. In addition, they need to bear in mind the links between the duty of confidentiality and other legislation. For example, the Human Rights Act takes a broad perspective, placing a strong emphasis on the ability to override the right to privacy in the interests of the welfare of the child, and this is in line with the safeguarding duties in the Children Act 2004. The Nursing and Midwifery Council provide guidance on confidentiality on their website

and note that where a decision has been made to break confidentiality there is a need to fully document the reasons for sharing information[10]

Where there is a potential need to disclose information, this should be discussed with line managers, and if appropriate local safeguarding services. Young people in secure settings are a vulnerable group, who may wish to disclose previous experiences of trauma or abuse. Staff should use the local guidance when explaining the parameters of confidentiality to young people. This is summarised on the Nursing and Midwifery Council website as the need to ensure people are informed about how and why information is shared by those who will be providing their care. If young people are aware that this may happen, this enables them to maintain a degree of trust and autonomy.

[10] www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Confidentiality/

5.3 Restraints

The CHAT aims to gather information for a comprehensive care plan which can highlight neurodisability or physical and mental health problems. This comprehensive care plan should be available to all staff working closely with young people, enhancing communication and the safe management of challenging behaviour. Furthermore, the quality and completeness of information and the effectiveness of communication should be audited and reviewed regularly.

Young people in secure settings are more likely to have health problems, a history of substance misuse and experiences of emotional deprivation and trauma, all of which will impact on their reaction to all interactions and particularly boundary setting, conflict resolution and the experience of restraint. The Ministry of Justice (2012) *Minimising and Managing Physical Restraint* document highlights a range of health problems which can increase the risk of complications during a restraint. All professionals completing the CHAT should ensure that they highlight any of these health problems in the CHAT comprehensive care plan and communicate these to other staff.

6 Summary

Comprehensive health screening has to be set in the overall context of many other initiatives taking place within the offender health programme. Critical issues that have arisen in several work streams include the continuing challenge of early identification of need, opportunities for prevention along the care pathway, avoidance of duplication and - above all for the young person - a real experience of continuity of care. There is a need to look at all domains of a young person's life beyond health including learning, social and family contexts. Finally it is acknowledged that young people in the secure estate are undergoing many transitions; community to secure settings, status as a young offender and transition from childhood to adulthood. The CHAT can provide an opportunity for a comprehensive assessment that can inform the way in which a young person is understood, this can range from assessing for autism or learning difficulties to re-engaging with treatment of asthma or epilepsy.

As a result of the project it is proposed that screening in reception is kept brief with inquiry into life threatening conditions only, but that everyone is then 'kept safe' with a full assessment of physical health, substance misuse, mental health and neurodisability issues within the suggested time frames and 'fast tracked' if needs are identified.

The resource intensive nature of these proposals are noted, multi-disciplinary and multi-agency commitment is required. Adequate staffing to ensure continuity of interventions whilst providing a comprehensive mental assessment for all will need to be a consideration for services during the roll out phase of the new instruments; the CHAT will need to be embedded within local pathways. Finally we acknowledge the commitment and enthusiasm of the staff working with children and young people who offend and hope that the manual and instruments will be seen as a way of enhancing recording of their excellent practice.

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